No. 04-(1)

Supreme Court, U.S.
FILED
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IN THE

Supreme Court of the United States

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,

v.

SHIRLEY O. FOUGHT,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the Tenth Circuit's decision, which irrebuttably presumes a conflict of interest from an insurance company's dual roles as funding source and ERISA claim fiduciary, and then shifts the burden to the insurer to defend its denial of benefits, exacerbates already great conflicts among the circuits and violates ERISA and the terms of ERISA-governed plans that grant discretion to insurers to determine claims, thereby eviscerating the arbitrary and capricious standard of review that this Court held applicable to discretionary benefits determinations in *Firestone*.

PARTIES TO THE PROCEEDING

Shirley O. Fought was the plaintiff in the district court and the appellant in the Tenth Circuit. UNUM Life Insurance Company of America was the defendant in the district court and the appellee in the Tenth Circuit.

RULE 29.6 DISCLOSURE STATEMENT

UNUM Life Insurance Company of America is a wholly-owned indirect subsidiary of UnumProvident Corporation, which is a publicly-traded corporation.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner UNUM Life Insurance Company of America ("UNUM") respectfully petitions this Court for a writ of certiorari to review the decision of the United States Court of Appeals for the Tenth Circuit, in order to provide direction on a critical and recurring question under the Employee Retirement Income Security Act of 1974 ("ERISA") as to which the courts of appeals are hopelessly at odds: The appropriate standard of review of an ERISA fiduciary's denial of benefits when (a) the plan vests the fiduciary with discretion, and (b) the fiduciary is an insurance company that also funds the plan through an insurance policy. The Court addressed this issue in a single sentence in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989): "Of course, if a benefit plan gives discretion to an administrator or fiduciary who is oper-

ating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* at 115 (quoting Restatement (Second) of Trusts § 187, comment d (1959)). In the ensuing fifteen years, the lower federal courts have struggled mightily to give effect to that statement, with confused, inconsistent, and in some instances—including the Tenth Circuit's decision in this case—illogical results that contradict the trust law principles underlying ERISA.

It is important that the Court exercise certiorari jurisdiction in this case. The Tenth Circuit held that an ERISA claim fiduciary that also serves as the third-party insurer for the plan has an inherent and irrebuttable conflict of interest. It further held that in cases reviewing denials of benefits by such inherently-conflicted fiduciaries, the burden of proof shifts to the insurer to affirmatively demonstrate that its denial was supported by substantial evidence. The Tenth Circuit's decision rests on the inaccurate and unfair presumption that whenever an insurer is both fiduciary and payor, those dual roles alone necessarily taint the carrier's resolution of claims. That presumption of bias is inconsistent with ERISA, which permits a fiduciary to serve as the plan's funding source. It also strips insurer fiduciaries of the very discretion that the Court held protected in *Firestone*.

Moreover, the Tenth Circuit is the first court of appeals to irrebuttably presume an actual conflict solely by virtue of an insurer's two roles. The decision conflicts with decisions of other circuits—which are themselves in conflict—and injects further discord into an area of the law that is already rife with confusion. This is an apt juncture for the Court to clarify for the lower courts, employers, fiduciaries, and claimants what the Court meant in that single sentence in *Firestone*.

Petitioner asks the Court to hold that (1) standing alone, an insurer's service as both fiduciary and payor does not affect the arbitrary and capricious standard of review, (2) the

burden is on the claimant to prove an actual conflict that improperly motivated the insurer's denial of benefits, and (3) a proven actual conflict should be considered as a factor in applying the still-controlling arbitrary and capricious standard of review, as the Court instructed in *Firestone*. This holding will achieve uniformity in the enforcement of ERISA; it will conform to commercial realities, in which insurers strive to meet their fiduciary obligations under ERISA and have little, if anything, to gain by denying meritorious claims; it will give insurer fiduciaries the necessary latitude to exercise their plan-granted discretion; and it will further Congress' objective of encouraging employers to provide ERISA benefit plans.

OPINIONS BELOW

The district court's unpublished memorandum opinion, dated May 31, 2002, is reproduced in the Appendix to this petition ("App.") at 70a. The initial opinion of the Tenth Circuit is reproduced at App. 33a. The substituted panel decision is reported at 379 F.3d 997 and reproduced at App. 1a.

JURISDICTION

The original judgment of the Tenth Circuit was entered on February 6, 2004. UNUM petitioned for rehearing and rehearing en banc. The panel granted rehearing and issued a substitute decision that was entered on August 13, 2004. The Tenth Circuit invited a renewed petition for rehearing en banc but denied UNUM's timely petition on October 26, 2004. Petitioners invoke the jurisdiction of this Court under 28 U.S.C. § 1254(1) (2000).

STATUTORY PROVISIONS INVOLVED

Section 404(a)(1) of ERISA, 29 U.S.C. § 1104(a)(1) (2000), defines fiduciary duties under the Act. Under Section 502(a) of the Act, *id.*, § 1132(a), a plan participant may bring a civil

action to redress a fiduciary's breach of its responsibilities. Relevant portions of these statutory provisions are set forth at App. 81a and App. 82a.

STATEMENT OF THE CASE

Factual Background. In May 1998, Ms. Fought enrolled for coverage under her employer's new disability benefits plan. Plan benefits were funded by a group policy of long-term disability insurance that UNUM had issued to the employer.

The plan designates UNUM as the claim administrator and gives UNUM discretionary authority to construe the terms and provisions of the plan and to determine claims. Court of Appeals Appellee's Supplemental Appendix ("C.A. Supp. App.") 329. The plan includes a pre-existing condition provision that applies to conditions that existed within three months before the employee's participation in the plan, and that excludes coverage for disabilities beginning in the first twelve months of coverage that were "caused by, contributed to by, or resulting from" any pre-existing condition. *Id.* at 341-42.

When Ms. Fought enrolled in the plan, she had a pre-existing condition as defined under the plan, because on March 16, 1998 (within three months before the effective date of her coverage), she had been diagnosed with various ailments, including a cardiac condition. In August 1998 she underwent angioplasty surgery, in March 1999 she underwent heart bypass surgery, and within weeks of the second surgery she developed a staph infection at the site of the incision. All of these medical events occurred in the first twelve months of coverage.

In June 1999, Ms. Fought applied for long-term disability benefits. All of her initial submissions to UNUM (the employer statement, employee statement, and attending physician's statement) stated that her disability began on varying

dates in March 1999, when the bypass surgery occurred. C.A. Supp. App. at 234, 242, 257. Those submissions identified the cause of her disability as "coronary artery disease," "heart attack," or "open heart surgery"—not the related staph infection. *Id.*

Because the disability began during the first year of coverage and was caused by Ms. Fought's cardiac condition, which had been diagnosed fewer than three months before the coverage took effect, UNUM denied her claim under the plan's pre-existing condition exclusion. Ms. Fought appealed and contended that the staph infection was a separate and unrelated cause of her disability. Even then, one of her doctors concluded that she was "totally disabled due to her heart condition." Court of Appeals Appellant's Appendix 154. (Ms. Fought falsified that doctor's report by deleting the words "due to her heart condition" when she submitted the document to UNUM in support of her appeal. *Id.* at 143-44.)

UNUM adhered to its original denial because, under its reading of the pre-existing condition exclusion, it perceived the staph infection as sufficiently related to the heart surgery to fall under that provision.

Proceedings Below. In challenging UNUM's denial of benefits, Ms. Fought invoked the jurisdiction of the district court under 29 U.S.C. § 1132(a)(1)(B) (2000) and 28 U.S.C. § 1331 (2000). Section 1132(a)(1)(B) provides a cause of action for a plan participant like Ms. Fought to "recover benefits due to [her] under the terms of [her] plan, to enforce [her] rights under the terms of the plan, or to clarify [her] rights to future benefits under the terms of the plan." The district court resolved the case on summary judgment.

Because the plan confers discretionary authority on UNUM, the district court began its analysis with the arbitrary and capricious standard of review under *Firestone*. App. 74a. However, the district court applied a "sliding scale abuse of

discretion" standard of review because, under prevailing law in the Tenth Circuit, UNUM was deemed to have an "inherent" conflict of interest merely by virtue of its dual role as claim fiduciary and payor of benefits. *Id.* at 74a-75a. The court concluded that UNUM did not abuse its discretion in construing the expansive language in its pre-existing condition provision as extending to both Ms. Fought's heart surgery and the staph infection, which was "a foreseeable complication of treatment." *Id.* at 75a-76a. On that basis, the district court granted summary judgment in favor of UNUM. *Id.* at 77a.

The Tenth Circuit issued two panel decisions. The initial panel decision was vacated on rehearing and replaced by the second decision.

Both the initial and second decisions reversed the district court on the basis that it had not applied the correct standard of review. In the second decision, as in the first, the Tenth Circuit began with these points: (1) Because the plan gives UNUM discretion to determine benefits and interpret the policy's provisions, the district court rightly applied an arbitrary and capricious standard of review, *id.* at 8a-9a; (2) under Tenth Circuit authority, because UNUM is both the claim fiduciary and insurer, it has an apparent conflict that must be weighed as a factor in applying the arbitrary and capricious standard, *id.* at 9a-10a; and (3) the Tenth Circuit has adopted a flexible sliding-scale approach that preserves the deferential review standard but also requires reviewing courts to "'decrease the level of deference given to the conflicted administrator's decision in proportion to the seriousness of the conflict.'" *Id.* at 10a-11a (quoting *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 825 (10th Cir. 1996)).

In both decisions, the Tenth Circuit then pronounced new law by adopting a two-tiered analysis that divides dual-role

claim fiduciaries into two rigid categories. According to the second panel decision:

- *Non-insurer* claim fiduciaries that both self-fund and administer benefit claims under a plan, have a "standard conflict of interest." The claimant must prove that the "standard" (or apparent) conflict is a "serious" (or actual) conflict. If the plaintiff proves an actual conflict, the burden shifts to the non-insurer fiduciary to justify its denial of benefits. Even if the plaintiff fails to prove an actual conflict, the mere apparent conflict is nevertheless considered as a factor that reduces the deference that otherwise would be accorded the conflict-free fiduciary's decision. App. 13a-14a.

- *Insurer* claim fiduciaries like UNUM have an "inherent conflict of interest." In all cases, the Tenth Circuit irrebuttably presumes that the inherent conflict was an actual conflict, and the burden shifts to the insurance company to defend its denial of benefits as supported by substantial evidence. *Id.* at 14a-17a. (In its initial decision, the court had imposed a preponderance of the evidence standard of proof on the insurer. *Id.* at 46a-50a. In response to UNUM's petition for rehearing, the panel abandoned this standard and substituted the substantial evidence standard.)[1]

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[1] In dictum, the Tenth Circuit extended its shifted-burden analysis to yet another circumstance, *i.e.*, "when a serious procedural irregularity exists." *Id.* at 14a. Without attempting to define such an irregularity, the court found "no question" that one existed in this case based on UNUM's failure to have ordered an independent medical examination ("IME"). *Id.* at 16a, 31a-32a. The court ignored the essentially undisputed medical fact that Ms. Fought developed a staph infection as a complication of surgery for a pre-existing coronary condition. The only issue was whether UNUM abused its discretion in concluding that the plan's pre-existing condition provision applied to those facts. An IME would not have had any bearing on UNUM's interpretation of its policy language. Ironically, within a month of the Tenth Circuit's decision, the Third Circuit reached

In both decisions, the Tenth Circuit relied almost exclusively on the views of a single commentator, whose recommendations do not flow logically from the first 84 pages of her law review article, and whose ultimate conclusions have not been embraced by any other court. *See* Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 Am. U. L. Rev. 1083 (2001) ("Kennedy"), *cited and quoted in* App. 9a, 13a-15a. In the second opinion, the court added as support for its "shifted burden" analysis cases involving exclusionary clauses in insurance policies. *See* App. 16a-17a n.4. But the court showed no sign of limiting its holding to exclusion cases. Rather, the Tenth Circuit an-nounced broad rules to be applied "in instances in which a fiduciary has a conflict of interest," *id.* at 12a, without apparent regard to whether the benefits denial rested on a coverage provision or an exclusion. In denying rehearing en banc, the Tenth Circuit declined UNUM's request that the court narrow its holding to exclusion cases.

Applying its new analysis, the Tenth Circuit repeatedly emphasized UNUM's concession of the existence of a conflict, *id.* at 2a, 6a, 16a, 31a, apparently without understanding that UNUM had admitted only an apparent conflict and had emphatically denied any actual conflict. App. 80a.[2] The court reversed the district court's conclusion that the

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the opposite conclusion, holding that a *request* for an IME constitutes a procedural irregularity that deprives a plan fiduciary of the otherwise applicable arbitrary and capricious standard of review. *See Kosiba v. Merck & Co.*, 384 F.3d 58 (3d Cir. 2004). The defendants in that case, including UNUM, are filing concurrently with this petition a petition for writ of certiorari to review the judgment of the Third Circuit.

[2] UNUM had no choice but to concede an apparent conflict because Tenth Circuit law presumes that an insurer is inherently conflicted. *See Pitman v. Blue Cross & Blue Shield of Okla.*, 217 F.3d 1291, 1296 (10th Cir. 2000). UNUM did not concede that its "inherent" conflict had any impact on the benefit determination, and Ms. Fought presented no evidence of any such impact.

denial of benefits was not arbitrary and capricious. *First*, giving no deference to UNUM's interpretation of the plan language, the Tenth Circuit rejected its application of the pre-existing condition exclusion to complications from treatment of such a condition. *Id.* at 19a-28a. *Second*, although acknowledging "the presence of conflicting evidence in the record" as to the cause of Ms. Fought's disability, the court held that UNUM did not "justif[y] its denial of benefits by substantial evidence." *Id.* at 30a, 32a.

REASONS FOR GRANTING THE WRIT

The Court's terse mandate in *Firestone*, that a fiduciary's conflict "must be weighed as a 'facto[r] in determining whether there is an abuse of discretion,'" 489 U.S. at 115 (citation omitted), has generated volumes of decisions documenting pervasive disagreement over related issues that arise almost daily: (a) The type of conflict—*e.g.*, an "apparent" or "inherent" conflict based on status versus an "actual" conflict—that should reduce the deference otherwise due to ERISA benefit determinations by fiduciaries with discretionary authority; and (b) how courts should "factor" such a conflict into the otherwise applicable arbitrary and capricious standard of review. There is particular disagreement about the application of *Firestone* to the facts in this case: An insurance company's service as both funding source and claim fiduciary, when the plan expressly vests the insurer with discretion.

The Tenth Circuit's decision creates even further conflict among the circuits on the standard of review in civil actions challenging insurer-fiduciaries' claim decisions. Given the prevalence of insured ERISA plans, particularly for small and mid-size employers, this fundamental and important issue arises in hundreds of cases annually. The disparate law at the circuit level disrupts ERISA's uniform enforcement scheme, inevitably leads to forum-shopping, foments litigation, and, ultimately, discourages the provision of ERISA benefits.

Petitioner requests this Court to overturn the Tenth Circuit's decision and resolve the circuit split. The Court should hold that an insurer's role as claim fiduciary, standing alone, has no impact on the otherwise applicable arbitrary and capricious standard of review. The Court also should hold that, even where a claimant proves the existence of an actual conflict, the arbitrary and capricious standard controls, but the actual conflict should be weighed as a factor in applying that standard of review.

I. THERE ARE MASSIVE SPLITS AMONG THE CIRCUITS ON THE ANALYSIS OF DUAL-ROLE CONFLICTS UNDER *FIRESTONE*.

The circuits are in general disagreement as to the meaning of *Firestone's* observation that if a fiduciary exercising discretionary authority under ERISA has a conflict of interest, courts must consider that conflict as a factor in reviewing a denial of benefits for abuse of discretion. The division among the courts of appeals exists on at least two levels: (a) What constitutes a "conflict" under *Firestone*; and (b) how are the courts to "'facto[r]'" that conflict into the otherwise applicable arbitrary and capricious (or abuse of discretion[3])

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[3] In *Firestone*, the Court used "arbitrary and capricious" and "abuse of discretion" interchangeably to describe the alternative to *de novo* review urged by Firestone. *Compare* 489 U.S. at 109 ("[lower] federal courts have adopted the arbitrary and capricious standard" as the appropriate standard under ERISA Section 502), *with id.* at 115 ("conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion'") (citation omitted). Similarly, with the exception of the Fourth and Seventh Circuits, the courts of appeals equate those two standards, treating any distinction between them as "semantic and not substantive." H. Brent McKnight, *Assessing the Impact of Conflict of Interest on the Decisions of ERISA Fiduciaries*, 13 Regent U.L. Rev. 1, 9 n.60 (2001); *see also* Annotation, *Judicial Review of Denial of Health Care Benefits Under Employee Benefit Plans Governed by Employee Retirement Income Security Act (ERISA)* (29 U.S.C.A. § 1132(a)(1)(B))—*Post-Firestone Cases*, 128 A.L.R. Fed. 1, § 29 (1995 & Supp.) (citing cases).

standard of review? This inconsistent body of law, which has become more fractured in the fifteen years since *Firestone*, cries out for clarification from this Court.

A. The Meaning of a Conflict Under *Firestone*.

The circuits fall into two general, but vastly divergent, camps as to when an insurer has a conflict that warrants adjusting the otherwise applicable arbitrary and capricious standard of review.

No presumption of actual conflict. Five courts of appeals—the First, Second, Seventh, Eighth, and Ninth Circuits—require an ERISA claimant to prove an actual or significant conflict before a court will apply less deference to the fiduciary's discretionary determination. Observing that "not every funding conflict of interest per se warrants heightened review," the Eighth Circuit has stated: "To obtain a less deferential review, [a claimant] must present material, probative evidence demonstrating that (1) a palpable conflict of interest . . . existed, which (2) caused a serious breach of the plan administrator's fiduciary duty to her." *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160-61 & n.2 (8th Cir. 1998) (citation omitted). The Seventh Circuit follows the same approach, presuming that an insurer fiduciary that pays claims out of its own assets "is acting neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict." *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998). "The existence of a potential [or apparent, structural, financial, or inherent] conflict is not enough." *Id.* *See also Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1998); *Whitney v. Empire Blue Cross & Blue Shield*, 106 F.3d 475, 477 (2d Cir. 1997) (per curiam); *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1322-23 (9th Cir. 1995).

Applying a law-and-economics rationale, these decisions recognize the forces that keep insurers from acting on their

apparent conflicts in a manner that would be contrary to the interests of plan participants. Insurers face market pressure to pay meritorious claims, at least if they want to retain or gain business. A carrier "can hardly sell policies if it is too severe in administering them." *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999). "Companies . . . who choose which group insurance policies they will use to fund their plans . . . have the sophistication and bargaining power necessary to take their business elsewhere if an insurer . . . consistently denies valid claims." *Mers*, 144 F.3d at 1021. Because "an employer would not want to keep an overly tight-fisted insurer[, t]he conflict is not as serious as might appear at first blush." *Doyle*, 144 F.3d at 184. In addition, given the large revenues of most insurers, the impact of particular claim denials on an insurer's bottom-line generally will be "not sufficiently substantial to threaten an administrator's impartiality." *Mers*, 144 F.3d at 1020-21.

Rebuttable presumption of actual conflict. Six courts of appeals—the Third, Fourth, Fifth, Sixth, Tenth, and Eleventh Circuits—reach the opposite conclusion, presuming an actual conflict based on the insurer's dual roles alone. The Sixth Circuit has rationalized its approach as follows: "Because an insurance company pays out to beneficiaries from its own assets rather than from the assets of a trust, its fiduciary role lies in perpetual conflict with its profit-making role as a business . . . ." *Miller v. Metro. Life Ins. Co.*, 925 F.2d 979, 984 (6th Cir. 1991); *but see Carr v. Reliance Standard Life Ins. Co.*, 363 F.3d 604, 606 & n.2 (6th Cir. 2004) (applying an unadulterated arbitrary and capricious standard of review to an insurer's claim denial, and suggesting that an inherent conflict will not alter the standard of review absent proof of actual impact on the decision under review). *See also Pitman v. Blue Cross & Blue Shield of Okla.*, 217 F.3d 1291, 1296 (10th Cir. 2000); *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 388-89 (3d Cir. 2000); *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 295 n.7 (5th Cir. 1999) (en banc);

Doe v. Group Hospitalization & Med. Servs., 3 F.3d 80, 86 (4th Cir. 1993); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1563 (11th Cir. 1990).[4]

However, until the Tenth Circuit's decision in this case, even in those circuits that presume an actual conflict when an insurer is also a claim fiduciary, the presumption is rebuttable. If the insurer demonstrates that its role as payor did not in fact affect its denial of benefits, then an unmodified arbitrary and capricious standard of review is applied. As stated by the Third Circuit: "We do not, of course, pretend to establish an absolute, per se rule, recognizing that different relationships between the parties could effect a different result." *Pinto*, 214 F.3d at 388 n.6 (quoting *Metro. Life Ins. Co. v. Potter*, 992 F. Supp. 717 (D.N.J. 1998), as case where insurer's inherent conflict was "'lessened, if not eliminated'" by plan's premium structure). Similarly, the Eleventh Circuit allows an insurer to "prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest." *Brown*, 898 F.2d at 1566; *see also Vega*, 188 F.3d at 295; *cf.*, *Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 234 (4th Cir. 1997) (an insurer's inherent conflict is "greatly mitigated" where the insurer relies on an IME).

Only the Tenth Circuit, by adopting an absolute rule that applies to all insurer fiduciaries without regard to the existence or absence of actual bias, renders the presumption of an actual conflict irrebuttable.

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[4] There is a similar divide on how to treat an *employer's* dual status as funding source and claim fiduciary under a self-funded plan. *Compare, e.g., Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1014 (5th Cir. 1992) (assuming actual conflict based merely on fact that "DuPont funds the Plan from current operating revenues, giving it an apparent incentive to deny benefits"), *with Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995) (declining to presume actual conflict based on employer's dual roles because "[t]he impact on a company's welfare of granting or denying benefits under a plan will not be sufficiently significant as to threaten the administrators' partiality [*sic*]").

B. The Impact of a Conflict Under *Firestone*.

The courts of appeals have taken three basic, but again very different, approaches to evaluating the impact of insurers' structural conflicts on the standard of review of ERISA benefits denials: (1) A sliding-scale analysis; (2) a presumptively-void analysis; and (3) a de novo analysis.

Sliding-scale approach. The First, Third, Fourth, Fifth, Sixth, Seventh, and Eighth Circuits apply some version of a sliding-scale approach, under which the reviewing court applies an arbitrary and capricious standard of review, but "integrate[s] conflicts as factors in applying that standard, approximately calibrating the intensity of [the] review to the intensity of the conflict." *Pinto*, 214 F.3d at 393. "The greater the evidence of conflict on the part of the administrator, the less deferential [the] abuse of discretion standard will be." *Vega*, 188 F.3d at 297; *see also Pari-Fasano v. ITT Hartford Life & Acc. Ins. Co.*, 230 F.3d 415, 419 (1st Cir. 2000); *Woo*, 144 F.3d at 1161-62; *Donato v. Metro. Life Ins. Co.*, 19 F.3d 375, 380 n.3 (7th Cir. 1994); *Doe v. Group Hospitalization*, 3 F.3d at 87; *Miller*, 925 F.2d at 984.[5]

Until the instant case, the Tenth Circuit also had approved the use of a sliding scale to "decrease the level of deference given to the conflicted administrator's decision in proportion to the seriousness of the conflict." *Chambers*, 100 F.3d at 825. In *Chambers*, the court "conclude[d] that the sliding scale approach more closely adheres to the Supreme Court's

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[5] In cases where the conflict is not deemed severe, application of the sliding-scale approach does not warrant a significant departure from a pure arbitrary and capricious standard, under which review is limited to determining whether the fiduciary's decision was reasonable and made in good faith, not whether it was the best or only "right" decision. *See, e.g.*, *Vega*, 188 F.3d at 301 (applying "only a modicum less deference than we otherwise would," where plaintiffs "demonstrated the minimal basis for a conflict [*i.e.*, the insurer's dual roles]," but "no evidence with respect to the degree of the conflict").

instruction to treat a conflict of interest as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* at 826 (quoting *Firestone*, 489 U.S. at 115); *see also, e.g.*, *Nance v. Sun Life Assur. Co. of Can.*, 294 F.3d 1263, 1269 (10th Cir. 2002); *McGraw v. Prudential Ins. Co. of Am.*, 137 F.3d 1253, 1258 (10th Cir. 1998).

Presumptively-void approach. The Ninth and Eleventh Circuits apply a presumptively-void approach: If "a plan beneficiary demonstrates a substantial conflict of interest . . . the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest." *Brown*, 898 F.2d at 1566; *see also Atwood*, 45 F.3d at 1323; *but see* Melissa Grant, *Battling for ERISA Benefits in the Ninth Circuit: Overcoming Abuse of Discretion Review*, S.W.U. L. Rev. 93, 129 (1998) ("[t]he Ninth Circuit approach to allegations of conflicts of interests in ERISA benefits disputes has been inconsistent[,]" with different panels employing sliding scale and presumptively void tests). If the fiduciary does not carry its burden of proof, the court applies de novo review—even where the plan vests the insurer-fiduciary with discretion. *See, e.g.*, *HCA Health Servs. of Ga., Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 995 (11th Cir. 2001); *Atwood*, 45 F.3d at 1323.

De novo review approach. The Second Circuit requires strict proof that a conflict actually influenced the administrator's decision, *see supra* at 11, but once the actual conflict is established, the court applies de novo review—affording no deference at all to the conflicted fiduciary's determination. *Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251, 1256 (2d Cir. 1996) (employer-fiduciary); *see also Whitney*, 106 F.3d at 477 (applying *Sullivan* analysis to insurer-fiduciary). The Eighth Circuit also has applied de novo review where the conflict is sufficiently "egregious." *Schatz v. Mut. of Omaha Ins. Co.*, 220 F.3d 944, 947 n.5 (8th Cir. 2000).

To this already-existing variety of approaches to an insurer-fiduciary's structural conflict of interest, the Tenth Circuit has added a wholly new analysis. Though purporting to merely "elaborate more fully" on its earlier articulation of the sliding scale approach, App. 12a, the court in fact discarded that authority. Now, under the decision below, reviewing courts no longer may cogently evaluate the unique facts of a case and "calibrate the reduced deference to the level of actual conflict that exists." *Hall v. UNUM Life Ins. Co. of Am.*, 300 F.3d 1197, 2005 (10th Cir. 2002). The court has forced all insurer-fiduciaries into a rigid box, in which the burden of proof automatically shifts to the insurer to prove that its denial was supported by substantial evidence. In so doing, the Tenth Circuit has adopted the very approach expressly rejected in *Chambers* and by other courts applying a sliding scale: That "a decision rendered by a conflicted plan administrator is presumed to be arbitrary and capricious." *Chambers*, 100 F.3d at 826.

C. The Need for Clarification.

The lower courts have left no doubt that when the Court broached the subject of conflicts in *Firestone*, it did not clarify the issue but instead perplexed courts and litigants. "Since *Firestone*, courts have struggled to give effect to this delphic statement [the single sentence], and to determine both what constitutes a conflict of interest and how a conflict should affect the scrutiny of an administrator's decision to deny benefits." *Pinto*, 214 F.3d at 383; *see also Williams v. BellSouth Telecomms., Inc.*, 373 F.3d 1132, 1138 (11th Cir. 2004) ("Supreme Court decisions have not explained" the meaning of heightened arbitrary and capricious review); *Pinto*, 214 F.3d at 393 ("[O]nly the Supreme Court can undo the legacy of *Firestone*."); *Abnathya v. Hoffman-La Roche, Inc.*, 2 F.3d 40, 45 (3d Cir. 1993) (noting criticisms of *Firestone* analysis of standard of review for structurally-conflicted fiduciaries exercising discretionary authority, and ob-

serving that "[p]erhaps the Supreme Court will have an opportunity to reconsider this issue").

As the en banc Fifth Circuit stated in 1999, "[i]n the [ten-year] interim since [*Firestone*], our Circuit has struggled with the appropriate standard of review for determinations by a self-interested administrator with discretionary authority," and "[o]ther Circuits have also struggled with the role a conflict of interest should play in determining whether an administrator has abused its discretion." *Vega*, 188 F.3d at 296 (citations omitted). *See also Doe v. Travelers*, 167 F.3d at 57 ("What constitutes a conflict and how the factor is to be weighed were not explained [in *Firestone*], and naturally the cases in the lower courts are now somewhat divided.") (footnote omitted); *Chambers*, 100 F.3d at 825-26 (noting conflict in circuits); *Buttram v. Central States, S.E. & S.W. Areas Health & Welfare Fund*, 76 F.3d 896, 900 n.6 (8th Cir. 1996) (same).[6]

Scholarly commentators also have emphasized the questions left unanswered in *Firestone*, the resultant conflicts in the circuits, and the need for answers from this Court. *See, e.g.*, Kevin Walker Beatty, *A Decade of Confusion: The Standard of Review for ERISA Benefit Denial Claims as Established by Firestone*, 51 Ala. L. Rev. 733, 750-51 (2000) (noting "the confusion among the circuit courts on key issues concerning the *Firestone* standard's application," which "chills uniformity of jurisprudence, one of ERISA's primary

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[6] During oral argument in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003), members of the Court inquired extensively about the post-*Firestone* treatment of fiduciary conflicts under ERISA. *See* 2003 WL 21006122, at **5-14, 21-23, 25-27 (transcript of April 28, 2003 argument). Counsel for all parties confirmed the split among the circuits concerning when an actual conflict exists and how it affects review of a fiduciary's discretionary decisions. *Id.* at **6, 21-22, 25. However, the sole issue in *Black & Decker* was the validity of a treating-physician rule under ERISA, and the Court's decision does not address the conflict issue.

goals"); Nola A. Kohler, Note, *An Overview of the Inconsistency Among the Circuits Concerning the Conflict of Interest Analysis Applied in an ERISA Action with an Emphasis on the Eighth Circuit's Adoption of the Sliding Scale Analysis in Woo v. Deluxe Corporation*, 75 N.D. L. Rev. 815, 822 & n.76 (1999) ("Since *Firestone*, the federal courts have grappled with the appropriate analysis for such situations without further guidance from the Supreme Court. The lack of any clear direction from the Supreme Court has generated inconsistency among the circuits . . . ."); John H. Langbein, *The Supreme Court Flunks Trusts*, 1990 S. Ct. Rev. 207, 208 (1990) ("[T]he Supreme Court in [*Firestone*] dealt with the problem so awkwardly that . . . [t]here is reason to think that . . . the Court will have to face the question anew.") ("Langbein").[7]

II. THE TENTH CIRCUIT'S DECISION CONFLICTS WITH *FIRESTONE*.

While the Court left critical questions unanswered in *Firestone*, leading to the conflicts summarized above, it confirmed that a fundamental purpose of ERISA is "'to protect contractually defined benefits.'" 489 U.S. at 113 (quoting *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985)). Consistent with that purpose and "established principles of trust law," "the benefit plan" must be the starting point for determining the scope of the fiduciary's authority. *Firestone*, 489 U.S. at 115. Therefore, "regardless of whether the administrator or fiduciary is operating under a possible or actual conflict of interest," *id.*, the standard of

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[7] Ironically, the primary source for the Tenth Circuit's contribution to the confused state of the law begins its analysis by decrying "the conflicts plaguing the circuits." Kennedy, 50 Am. U. L. Rev. at 1086. "These differences among the circuits have made it increasingly difficult to administer plans in a consistent fashion, despite ERISA's intent to present a uniform set of rules applicable to employee benefit plans." *Id.*

review must depend primarily on the intent of the contracting parties as stated in the plan. Where "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," courts *must* apply an arbitrary and capricious standard of review. *Id.* Where a plan grants discretionary authority to actually conflicted fiduciaries, deferential review still applies but the conflict should be "weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* (citation omitted). In reaching these conclusions, the Court rejected the approach of the Third Circuit, which had looked only to the status of the plan administrator, not to the plan itself:

> The Court of Appeals held that where an employer is itself the fiduciary and administrator of an unfunded benefit plan, . . . deference is unwarranted given the lack of assurance of impartiality on the part of the employer . . . . Because we do not rest our decision on the concern for impartiality that guided the Court of Appeals, we need not distinguish between types of plans or focus on the motivations of plan administrators and fiduciaries.

Id. at 107-08, 115 (citations omitted).

The Tenth Circuit's decision in this case cannot be reconciled with these holdings in *Firestone*. The court of appeals' "inherent conflict" analysis makes presumed partiality the sole criterion for selecting the standard of review, rather than just one of several relevant factors under trust law—just as the Third Circuit erroneously did in *Firestone*. The Tenth Circuit's shifted burden analysis—which creates a presumption of wrongdoing that the fiduciary must rebut—renders the terms of the controlling plan documents virtually meaningless.[8]

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[8] The Court's consideration of conflicts in *Pegram v. Herdrich*, 530 U.S. 211 (2000), further highlights the defects in the Tenth Circuit's pre-

The Tenth Circuit's presumption of actual partiality also conflicts with ERISA itself. Congress expressly authorized employers to provide insurance benefits (*e.g.*, life, health, and disability benefits) to employees. *See* 29 U.S.C. § 1002(1) (2000) (defining an employee welfare benefit plan as a plan that provides one or more specified types of benefits "through the purchase of insurance or otherwise"). Despite ERISA's comprehensive prohibitions on conflicts of interest, *see* 29 U.S.C. §§ 1106-1107 (2000), the statute permits employers and insurers to serve as fiduciaries. *Id.* § 1108(c)(3); *see* Langbein, 1990 S. Ct. Rev. at 213 (discussing "ERISA's authorization of nonneutral fiduciaries"). Because service as a fiduciary necessarily requires the exercise of discretion, *see id.* § 1002(21)(A), Congress intended insurer-fiduciaries to exercise discretion. Yet, the Tenth Circuit's decision, in abolishing traditional arbitrary and capricious review of insurers' benefits determinations, tramples on that congressional intent.

III. THE APPROPRIATE STANDARD OF REVIEW FOR INSURER FIDUCIARIES EXERCISING DISCRETIONARY AUTHORITY IS A RECURRING ISSUE OF NATIONAL IMPORTANCE TO CLAIMANTS, EMPLOYERS, AND FIDUCIARIES.

The interest in uniformity. In enacting ERISA, Congress sought to foster a "uniformity of decision" to "help ad-

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sumed conflict analysis. In *Pegram*, the Court acknowledged the inherent financial conflict for HMO physicians who often receive profit-sharing incentives to ration care and, therefore, whose "financial interest lies in providing less care, not more." *Id.* at 219. Yet, the Court further recognized that "[t]he check on this influence . . . is the [doctor's] professional obligation to provide covered services with a reasonable degree of skill and judgment in the patient's interest." *Id.* Here, there is a similar check on the apparent conflict that insurers confront when they also serve as plan fiduciaries, *i.e.*, the very fact that they *are* fiduciaries who would face exposure under ERISA for proven self-dealing in violation of their fiduciary responsibilities.

ministrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws." S. Rep. No. 93-127, at 29 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4848, 4865. Congress wanted to "ensure that plans and plan sponsors would be subject to a uniform body of benefits law" so as to "minimize the administrative and financial burden of complying with conflicting directives," *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)—"burdens ultimately borne by the [plan's] beneficiaries." *Egelhoff v. Egelhoff*, 532 U.S. 141, 150 (2001). However, "[u]niformity is impossible" if different courts subject plans to "different legal obligations." *Id.* at 148. *See also Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987) ("uniform administrative scheme" intended under ERISA would be "difficult to achieve" if a plan were required "to process claims in a certain way in some States but not in others").[9]

The vast divisions in the circuit court decisions described above defeat Congress' goal of uniformity. Uncertainty regarding the law breeds litigation. Absent review by this Court, the Tenth Circuit's decision will lead to even more forum-shopping under ERISA's liberal venue provision, which permits the filing of suit to recover benefits "in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found." 29 U.S.C. § 1132(e)(2) (2000).[10] And it will be inequitable to

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[9] The cited cases all considered the need for uniform law in the context of preemption under ERISA of varying state laws. The underlying interest in uniformity, however, applies equally to the federal courts' application of the Act.

[10] The courts have construed the "may be found" language as providing for venue in any district in which the defendant has minimum contacts sufficient to establish personal jurisdiction. *See I.A.M. Nat'l Pension Fund, Benefit Plan A v. Wakefield Indus., Inc.*, 699 F.2d 1254, 1257-58 (D.C. Cir. 1983); *Varsic v. United States Dist. Court for the Central Dist. of Cal.*, 607 F.2d 245, 248 (9th Cir. 1979).

employers, participants, and fiduciaries in different federal circuits.

In short, only a ruling by this Court can provide the uniformity that Congress intended to establish by enacting ERISA and that is now so obviously lacking.

The interest in encouraging ERISA plans. A prime purpose underlying ERISA was to encourage the formation of employee benefit plans, including disability plans. *See* 29 U.S.C. § 1001(a) (2000) (employee benefit plans "have become an important factor affecting the stability of employment and the successful development of industrial relations"). Nevertheless, provision of welfare and retirement benefits is voluntary: "Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995). Well aware of this freedom, Congress cautioned that plans should not be so heavily burdened by regulation that "employers respond . . . by decreasing benefits under existing plans or slowing the rate of formation of new plans." H.R. Rep. No. 93-807, at 15 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4670, 4682. *See also Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (recognizing Congress' "desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place") (citations omitted).

The Tenth Circuit's decision, by irrebuttably presuming an actual conflict and requiring insurer fiduciaries to defend every claim denial in a civil action, will foment appeals and, hence, will create a new and costly litigation burden that will raise the costs of plan administration. As insurers' costs needlessly rise—based on knee-jerk assumptions rather than actual evidence of bias—so employers' costs will increase, too. Inevitably, some employers will either reduce their plans' coverage or decline to offer those benefits at all. Ei-

ther result runs directly contrary to "the public interest in encouraging the formation of employee benefit plans." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). Again, even the Tenth Circuit's primary authority acknowledges this inevitable by-product of the court's unduly harsh approach:

> If all that is needed is proof of a potential or actual conflict of interest, there is little to lose in challenging a benefits denial case . . . . For small-and-medium-sized employers, the costs of litigation will increase the administrative costs of the plan, making it even more difficult to sponsor and maintain. This result is obviously in conflict with the initial purpose of ERISA to continue the growth and development of privately-sponsored employee benefit plans.

Kennedy, 50 Am. U. L. Rev. at 1088, 1162 (footnote omitted); *see also Vega*, 188 F.3d at 298 (en banc Fifth Circuit recognizing that a burden-shifting approach "would also violate basic principles of judicial economy").

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted, and the judgment of the Tenth Circuit reversed.

Respectfully submitted,

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January 24, 2005

APPENDIX A

UNITED STATES COURT OF APPEALS
TENTH CIRCUIT

[Filed Aug. 13, 2004]

No. 02-2176

SHIRLEY O. FOUGHT,
Plaintiff-Appellant,

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Defendant-Appellee.

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEW MEXICO
(D.C. NO. CIV-01-124)

Robert P. Warburton (Ray M. Vargas, II, with him on the briefs), Sheehan, Sheehan & Stelzner, P.A., Albuquerque, New Mexico, for Plaintiff-Appellant.

Kathryn D. Lucero (Kerri L. Peck, with her on the brief), Foster, Johnson, McDonald, Lucero, Koinis, LLP, Albuquerque, New Mexico, for Defendant-Appellee.

Before TACHA, McKAY, and HENRY, Circuit Judges.

PER CURIAM

Shirley O. Fought challenges the decision by UNUM's claims administrator to deny long-term disability benefits under her employer's group disability plan. A severe staph infection that followed elective heart surgery hospitalized and

disabled Ms. Fought. UNUM's plan administrator denied coverage by concluding that Ms. Fought suffered from a pre-existing coronary artery condition that "caused," "contributed to," or "resulted" in Ms. Fought's disability, citing language in the plan. After exhausting the company's internal appeals process, Ms. Fought brought a civil suit under 29 U.S.C. § 1132(a)(1)(B), alleging that she was entitled to disability benefits under the plan. UNUM admitted to a conflict of interest, as both payor and administrator of the plan. The magistrate judge denied discovery regarding the extent of UNUM's conflict of interest. The district court then granted summary judgment in favor of UNUM.

Exercising jurisdiction under 28 U.S.C. § 1291, we hold that the district court did not apply the appropriate standard of review when it considered the plan administrator's denial of benefits to Ms. Fought. Applying the correct standard of review, we reverse the grant of summary judgment in favor of UNUM and remand to the district court for further proceedings.

I. BACKGROUND

A. Undisputed Facts

On May 18, 1998, Ms. Fought enrolled in her employer's group long-term disability plan, which was issued by UNUM with an effective date of June 1, 1998. The policy, under a provision entitled "What disabilities are not covered under your plan?" states: "Your plan does not cover any disabilities caused by, contributed to by, or resulting from your . . . pre-existing condition." Aple's Supp. App. at 341-42.

The policy does not define the terms "caused by, contributed to by, or resulting from." The policy provides the following details regarding a pre-existing condition:

> You have a pre-existing condition when you apply for coverage when you first become eligible if:

> —you received medical treatment, consultation, care or services including diagnostic measure or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; or you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the 3 months just prior to your effective date of coverage; and
>
> —the disability begins in the first 12 months after your effective date of coverage.

Id. at 342.

Prior to her enrollment in the plan, Ms. Fought had been diagnosed and treated for coronary artery disease. In August 1998, approximately three months after her enrollment in the plan, Ms. Fought underwent angioplasty. On March 8, 1999, she was admitted for unstable angina syndrome, and on March 15, 1999, she underwent an elective coronary artery revascularization surgery. During surgery, the doctors discovered that Ms. Fought's sternum was narrow and osteoporotic, requiring a special procedure to close the surgical wound. Her doctors noted that "her postoperative course was anticipated to be quite challenging[,] given the concerns about the wound." Aplt's App. at 79. She was discharged six days after surgery on March 22, 1999. "At the time of [her] discharge, there [was] no evidence of infection," and "her wounds were healing well." *Id.* at 83; 166.

Three weeks later, the incision from Ms. Fought's wound became "dehisced," or split open. On April 8, 1999, she was readmitted for care of her dehisced sternal wound and a possible infection. Aple's Supp. App. at 97.

At this time, her wound cultures tested positive for a "few" Klebsiella pheumonia bacteria. She was placed on antibiotics and given intensive wound care to prevent infection. After a hospital stay of five days, and a "dramatic improvement in the appearance of the wound," she was sent to a skilled nursing facility. Aplt's App. at 85. At the time, the "wound

appearance looked satisfactory." *Id.* at 85. She was discharged from the facility on April 19, 1999.

On May 7, 1999, Ms. Fought complained of right-side chest pain. She was readmitted to the hospital on May 11, 1999, with a white blood cell count of 12,000 and a low grade fever. Two exposed sternal wires were detected. Her sternal wound and blood cultures were positive for both Klebsiella pneumonia and methicillin-resistant Staphylococcus aureus in the sternal wound and methicillin-resistant Staphylococcus aureus in the blood stream. *Id.* at 139.

Ms. Fought was placed in the Intensive Care Unit. Over the next two months, she underwent various operative procedures, was intubated, and received hemodyanmic monitoring, nutritional support, and sedation. One surgery involved extensive sternal wound reconstruction and required Ms. Fought to be placed on a ventilator. She was discharged on July 15, 1999, when she was transferred to another facility for intensive wound care.

On September 13, 1999, UNUM denied coverage under the long-term disability plan, having determined that Ms. Fought's pre-existing condition "caused, contributed to, or resulted in the condition(s) for which [she was] claiming disability." Aplt's App. at 33-34 (Letter to Ms. Fought from Anne Dionne, Disability Benefit Specialist, dated Sept. 13, 1999). Ms. Fought submitted a formal request to have her claim reopened, *see id.* at 143 (Letter from Ms. Fought to Ann Dionne, dated Oct. 19, 1999), as well as letters from three doctors certifying that the staph infection was neither a pre-existing condition nor related to her pre-existing coronary artery disease. *Id.* at 156 (Note from Dr. Robert T. Ferraro, dated Oct. 19, 1999) ("[T]he staph infection which is the basis for multiple wounds on chest is not related to coronary artery disease. *This is a separate, unrelated diagnosis without preceding history.*") (emphasis added); *id.* at 154 (Note from Dr. Robert Dubroff, dated Oct. 22, 1999) ("[Ms.] Fought is

totally disabled due to her heart condition. *The staph infection was not a pre-existing condition.*") (emphasis added); *id.* at 155 (Note from Dr. Neil T. Chen, undated) ("[Ms.] Fought's chest & abdominal wounds/infection is [sic] *not* a preexisting condition.") (emphasis in original).

UNUM's medical department reviewed Dr. Ferraro's letter,[1] but the company declined to reverse its previous decision, stating that although "the staph infection itself was not present during the pre-existing condition period (3/1/98-5/31/98), it was the result of surgery that was performed for a cardiac condition that was present, diagnosed and treated during that time frame." *Id.* at 147-48 (Letter to Ms. Fought from Anne Dionne, dated Oct. 25, 1999).

Ms. Fought then retained legal counsel, who contacted UNUM's Long-Term Disability Quality Review Section, and informed the company that Ms. Fought was appealing the denial of coverage. *See id.* at 159. After a review, UNUM again denied coverage, stating that "the staph infection was

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[1] The letter from UNUM does not mention the other doctors' letters, saying only that "Dr. Ferraro's note was reviewed by our medical department." Aplt's App. at 147. Apparently, the other two doctors' letters were faxed to UNUM on October 25, 1999, the very day that UNUM sent Ms. Fought the letter confirming its denial of disability benefits. *See id.* at 146. "Plan administrators, of course, may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician." *Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965, 1972 (2003). We note that UNUM's subsequent review, *see* Aplt's App. at 150, appeared to include consideration of Ms. Fought's additional doctors' notes.

We also note that the parties do not argue that the plan administrator misallocated the weight it gave to the treating physician's opinion, so the admonishments of *Black & Decker* do not apply. *See Black & Decker*, 123 S. Ct. at 1972 ("[W]e hold [that] courts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant's physician; nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation.").

the result of surgery performed for a cardiac condition that was caused by, contributed to by, or resulted from the cardiac condition that was present, diagnosed and treated during the pre-existing period." *Id.* at 150 (Letter from John J. Schifano, Senior Benefit Analyst, dated Dec. 2, 1999).

Finally, Ms. Fought contacted the New Mexico Public Relations Commission, which corresponded with UNUM concerning Ms. Fought's situation. Responding to the state agency's inquiry, UNUM explained that the staph infection was the result of coronary bypass surgery, which was performed to treat her pre-existing condition. "She would not have had to have the surgery, later developing an infection, if she did not have the cardiac conditions which were present and treated for during the pre-existing period." *Id.* at 158 (Letter from Theresa-Ann Uminga, Senior Complaints Specialist, to James A. Chavez, Ms. Fought's Attorney, dated Feb. 11, 2000).

B. Procedural History

In August 2001, Ms. Fought filed suit in federal district court alleging UNUM violated 29 U.S.C. § 1132 in denying her claim for benefits. UNUM admitted that it operated under a conflict of interest, *id.* at 12 (Memorandum Opinion and Order Granting Defendant's Motion for Summary Judgment, filed May 31, 2002), because it both administers claims and is the payor of those claims. Ms. Fought requested discovery to allow inquiry into the extent of UNUM's conflict of interest. The magistrate judge denied this request.

UNUM moved for summary judgment. The district court, acknowledging the conflict of interest, proceeded to interpret the contract language "caused by, contributed to by, or resulting from" as meaning "related to" and "foreseeable complication of" a pre-existing condition. The district court ruled that the "staph infection [was] related to the coronary artery disease as a foreseeable complication of treatment." Aplt's App. at 14. On that basis, the district court granted

UNUM's motion for summary judgment, concluding that UNUM's decisions to deny Ms. Fought long-term disability benefits were not arbitrary or capricious, and ordered Ms. Fought to pay UNUM's costs. Ms. Fought now appeals.

II. ANALYSIS

UNUM's long-term disability plan is governed by the Employee Retirement and Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.* "ERISA was enacted to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (citations and internal quotation marks omitted); *see also* 29 U.S.C. § 1001(b) ("It is hereby declared to be the policy of this chapter to protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans.").

In seeking coverage under her long-term disability benefit plan, Ms. Fought advances three arguments. First, she argues that the district court erred by using the wrong standard of review when it reviewed UNUM's decision. Second, she argues that UNUM's denial of benefits was, in any event, an unreasonable interpretation under the plan. Finally, she argues that the district court failed to consider UNUM's obligation to draft plan provisions in a manner calculated to be understood by the average plan participant.

We begin with the appropriate standard of review, discussing (1) the current state of the Tenth Circuit's "sliding scale" standard of review, (2) the application of the sliding scale standard of review in conflict of interest cases, (3) the application of a reduced deference standard in this case.

We then combine our analysis of Ms. Fought's second and third arguments. Given our standard of review, we first analyze whether the plan administrator's construction of the

plan language is a reasonable one. In so doing, we consider (a) the plan's pre-existing exclusion clause, (b) the role of causation in interpreting the pre-existing exclusion clause, (c) the Department of Labor's regulations and a published example regarding pre-existing conditions, (d) relevant circuit and district court case law involving similar questions, and (e) whether clearer exclusionary language may have been available to UNUM. Finally, we examine whether, given the record evidence and our reduced deference standard of review, UNUM's application of the pre-existing condition exclusion was supported by substantial evidence.

A. The Standard of Review

"Summary judgment orders are reviewed de novo, using the same standards as applied by the district court." *Pitman v. Blue Cross & Blue Shield of Okla*, 217 F.3d 1291, 1295 (10th Cir. 2000). Accordingly, like the district court, we must review UNUM's decision to deny benefits to Ms. Fought, and we must determine the appropriate standard to be applied.

The Supreme Court provided important guidance regarding the standard of review in ERISA benefits cases in *Firestone*, 489 U.S. at 113-15. The Court noted that deference to expert administrators is grounded in the most fundamental premises of trust law. If a disinterested party exercising discretionary powers has looked at evidence and rendered a decision, it is not only reasonable but a wise conservation of judicial resources not to have judges replicate the administrator's work. *See id.*

Recognizing that parties to a contract can agree to vest discretionary authority in an administrator, the Supreme Court held that "a denial of benefits challenged under § 1132(a)(1)(B) [ERISA] is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115.

There is no dispute that here the plan expressly gives UNUM, as plan administrator, the discretion to determine whether to deny a claimant insurance benefits under the plan. Aplt's. App. at 31. Therefore, because the plan grants UNUM discretion, "[a] court reviewing a challenge to a denial of employee benefits . . . applies an 'arbitrary and capricious' standard to a plan administrator's actions." *Charter Canyon Treatment Ctr. v. Pool Co.*, 153 F.3d 1132, 1135 (10th Cir. 1998). "[O]ur review is limited to determining whether [the plan administrator's] interpretation was reasonable and made in good faith." *Hickman v. GEM Ins. Co.*, 299 F.3d 1208, 1213 (10th Cir. 2002). "[A]ssuming full and expansive discretion has been conferred, then the plan administrator's interpretation of ambiguous plan provision should be judged as follows: (a) as a result of reasoned and principled process (b) consistent with any prior interpretations by the plan administrator (c) reasonable in light of any external standards and (d) consistent with the purposes of the plan." Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U.L. REV. 1083, 1135, 1172 (2001) (hereinafter, Kennedy, *Judicial Standard*) (summarizing and recommending the Fourth Circuit's current set of reasonableness factors). Finally, in reviewing a plan administrator's decision under the arbitrary and capricious standard, "the federal courts are limited to the 'administrative record'—the materials compiled by the administrator in the course of making his decision." *Hall v. UNUM Life Ins. Co. of Am.*, 300 F.3d 1197, 1201 (10th Cir. 2002).

The possibility of an administrator operating under a conflict of interest, however, changes the analysis. *Caldwell v. Life Ins. Co. of N. Am.*, 287 F.3d 1276, 1282 (10th Cir. 2002) ("Indicia of arbitrary and capricious decisions include . . . conflict of interest by the fiduciary."). Thus, "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an

abuse of discretion.'" *Firestone*, 489 U.S. at 115 (quoting RESTATEMENT (SECOND) OF TRUSTS § 187, cmt. d (1959)).[2] "The rationale for this approach is clear. A conflicted fiduciary may favor, consciously or unconsciously, its interests over the interests of the plan beneficiaries." *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556, 1565 (11th Cir. 1990); *see also Pitman*, 217 F.3d at 1296 ("'[W]hen an insurance company serves as ERISA fiduciary . . . , it is exercising discretion over a situation for which it incurs direct, immediate expense as a result of benefit determinations favorable to plan participants.'") (quoting *Brown*, 898 F.2d at 1561).

Following *Firestone*, the various circuit courts attempted to put the Court's instructions into practice. "Since *Firestone*, all of the circuit courts agree that a conflict of interest triggers a less deferential standard of review. The courts, however, differ over how this lesser degree of deference alters their review process." *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 825 (10th Cir. 1996).

1. Sliding Scale

In *Chambers*, we identified two basic approaches that had emerged in interpreting *Firestone*: the "sliding scale" approach and the "presumptively void" approach. We explicitly adopted the former. *Id.* at 826-27.

"Under [the sliding scale] approach, the reviewing court will always apply an arbitrary and capricious standard, but the

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[2] We continue to treat the terms "arbitrary and capricious" and "abuse of discretion" as interchangeable in this context. *See Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 825 n.1 (10th Cir. 1996) ("Some circuit courts have recently distinguished between these two standards and have concluded that the abuse of discretion standard is more appropriate. Most courts, however, have held that this is a distinction without a difference. We agree and adhere to the arbitrary and capricious standard of review.") (internal citations and quotation marks omitted).

court must decrease the level of deference given to the conflicted administrator's decision in proportion to the seriousness of the conflict." *Id.* at 825; *see also Ladd v. ITT Corp.*, 148 F.3d 753, 754 (7th Cir. 1998) (noting that when "the administrator has a conflict of interest, then, though the standard of review is nominally the same, the judicial inquiry is more searching"); *Spangler v. UNUM Life Ins. Co. of Am.*, 38 F. Supp. 2d 952, 955-56 (N.D. Okla. 1999) (noting that where conflict of interest is "apparent," further discovery is not required; "the court's review is a little more searching . . . and the court is not as quick to defer to the administrator's discretion"). "[F]lexibility in the scope of judicial review need not require a proliferation of different standards of review; the arbitrary and capricious standard may be a range, not a point. There may be in effect a sliding scale of judicial review of trustees' decisions." *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052 (7th Cir. 1987); *Chambers*, 100 F.3d at 826 (quoting *Van Boxel* for same proposition). Therefore, we recognize that "the wholesale importation of the arbitrary and capricious standard into ERISA is unwarranted." *Firestone*, 489 U.S. at 109.

To say that there is a sliding scale of deference, however, merely begs the question: *how much* less deference ought a reviewing court afford? Our past opinions in this area do not clearly address this question. *See, e.g., McGraw v. Prudential Ins. Co. of Am.*, 137 F.3d 1253, 1258 (10th Cir. 1998) (recognizing the arbitrary and capricious standard as "inherently flexible" in that "the degree of deference . . . will be decreased on a sliding scale in proportion to the extent of conflict" without providing guidance as to what a deference reduction entails). Our failure to articulate clearly the requirements of a less deferential arbitrary and capricious standard

has left district courts in this circuit without direction and has encouraged litigation.[3]

2. Defining the sliding scale

In light of this lack of clarity, we capitalize on this opportunity to elaborate more fully what a less deferential standard of review entails. We adopt the following standards for reducing deference in instances in which a fiduciary has a conflict of interest because it (1) adheres to ERISA common law, (2) promotes sound public policy, and (3) provides

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[3] Our review of the law reveals a similar lack of direction from other circuits. *See, e.g., Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 390-93 (3d. Cir. 2000) (holding, without providing further guidance, that the deference accorded the fiduciary will be lessened by the degree necessary to neutralize influence resulting from conflict); *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 296 (5th Cir. 1999) (stating only that the "deference [provided to the administrator] will be lessened to the degree necessary to neutralize any untoward influence resulting from the conflict"); *Borda v. Hardy, Lewis, Pollard & Page, P.C.*, 138 F.3d 1062, 1069 (6th Cir. 1998) (concluding that the fiduciary will be entitled to some deference, but that "application of the standard should be shaped by the circumstances of the inherent conflict of interest"); *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 n.1 (7th Cir. 1998) (recognizing that "[t]he arbitrary and capricious standard does not pose an all-or-nothing choice between full deference or none"); *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161-62 (8th Cir. 1998) (describing the sliding scale as extremely flexible in that courts may adjust for all relevant circumstances). The Third Circuit states this well:

> We acknowledge that there is something intellectually unsatisfying, or at least discomforting, in describing our review as a "heightened arbitrary and capricious" standard. The locution is somewhat awkward. The routine legal meaning of an "arbitrary and capricious" decision is that used, quite understandably, by the district court: a decision "without reason, unsupported by substantial evidence or erroneous as a matter of law." Once the conflict becomes a "factor" however, it is not clear how the process required by the typical arbitrary and capricious review changes.

Pinto, 214 F.3d at 392.

clearer guidance to lower courts, lawyers, and potential litigants. First we consider the scenario in which a fiduciary plays more than one role pursuant to ERISA, which creates a conflict of interest. In such situations, if the plaintiff cannot establish a serious conflict, then we will view the conflict of interest as one factor in determining whether the plan administrator's denial of benefits was arbitrary and capricious. Second, we craft a burden-shifting rule for fiduciaries that have an inherent conflict of interest. In such instances, the burden is on the fiduciary to establish by substantial evidence that the denial of benefits was not arbitrary and capricious.

A. Standard conflict of interest

ERISA envisions that a fiduciary "may 'wear two hats,' one of a trustee or fiduciary and one of a settlor." *See* Kennedy, *Judicial Standard*, 50 AM. U.L. REV. at 1161; *see* 29 U.S.C. § 1102(c)(1) ("[A]ny person or group of persons may serve in more than one fiduciary capacity with respect to the plan."). We hold that in every case in which the plan administrator operates under a conflict of interest—or a "standard" conflict of interest case—the plaintiff is required to prove the existence of the conflict." Kennedy, *Judicial Standard*, 50 AM. U.L. REV. at 1173. "Evidence of a conflict of interest requires 'proof that the plan administrator's dual role jeopardized his impartiality.'" *Cirulis v. UNUM Corp.*, 321 F.3d 1010, 1017 n.6 (10th Cir. 2003) (quoting *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1097 (10th Cir.1999).

> [T]he mere fact that the plan administrator was a [company] employee is not enough *per se* to demonstrate a conflict. Rather, a court should consider various factors including whether: (1) the plan is self-funded; (2) the company funding the plan appointed and compensated the plan administrator; (3) the plan administrator's performance reviews or level of compensation were

> linked to the denial of benefits; and (4) the provision of benefits had a significant economic impact on the company administering the plan.

Id. (internal quotation marks omitted). If the plaintiff cannot establish a serious conflict of interest, we consider defendant's standard conflict of interest as one factor in determining whether defendant's denial of disability benefits to plaintiff was arbitrary and capricious. *See Firestone*, 489 U.S. at 115 (holding that when "a benefit plan gives discretion to an administrator . . . who is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion") (internal quotations omitted); *Charter Canyon Treatment Ctr. v. Pool Co.*, 153 F.3d 1132, 1135 (10th Cir. 1998) (where a plan administrator is operating under a conflict of interest, "the court may weigh that conflict as a factor in determining whether the plan administrator's actions were arbitrary and capricious").

B. Inherent conflict of interest

When the plan administrator operates under either (1) an inherent conflict of interest, Kennedy, *Judicial Standard*, 50 AM. U.L. REV. at 1173); *see also Pitman*, 217 F.3d at 1296 n.4 (noting that "as both insurer and administrator of the plan, there is an inherent conflict of interest between its discretion in paying claims and its need to stay financially sound"); (2) a proven conflict of interest; or (3) when a serious procedural irregularity exists, and the plan administrator has denied coverage, an additional reduction in deference is appropriate. Under this less deferential standard, the plan administrator bears the burden of proving the reasonableness of its decision pursuant to this court's traditional arbitrary and capricious standard. *See* Kennedy, *Judicial Standard*, 50 AM. U.L. REV. at 1174. In such instances, the plan administrator must demonstrate that its interpretation of the terms of the plan is reasonable and that its application of those terms to the claimant is supported by substantial evidence. The district

court must take a hard look at the evidence and arguments presented to the plan administrator to ensure that the decision was a reasoned application of the terms of the plan to the particular case, untainted by the conflict of interest.

Professor Kennedy suggests a procedure for decreasing deference in inherent conflict of interest cases that we find persuasive.

> [T]o further protect participants and beneficiaries in such conflict of interest contexts, [courts should] shift[] the burden to the fiduciary to justify the reasonableness of its decision. This puts the plan administrator on notice that its decisions will be judged for their reasonableness and provides the courts with a record that must show that the conflict of interest did not taint such decision. Such a result is still consistent with the *Firestone* admonition to consider as a factor any conflict of interest, but provides more direction for the courts in the application of the reasonableness standard.

Id. at 1174.

This burden-shifting approach for such conflict of interest cases has numerous advantages. First, as noted, it comports with our post-*Firestone* holdings that, even in cases of conflict of interest, the arbitrary and capricious standard provides the appropriate level of review. *See Chambers*, 100 F.3d at 827 ("[T]he arbitrary and capricious standard is sufficiently flexible to allow a reviewing court to adjust for the circumstances alleged, such as trustee bias in favor of a third-party or self-dealing by the trustee.") (quotation marks omitted); *see also Jones v. Kodak Med. Assistance Plan*, 169 F.3d 1287, 1291 (10th Cir. 1999) (noting that we are required to "decreas[e] the level of deference in proportion to the severity of the conflict"); *Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 233 (4th Cir. 1997) ("The more incentive for the administrator or fiduciary to benefit itself by a certain inter-

pretation of benefit eligibility or other plan terms, the more objectively reasonable the administrator or fiduciary's decision must be and the more substantial the evidence must be to support it."). Second, it provides clear direction to district courts, lawyers, and potential litigants. Third, it provides the less deferential review that we must accord an inherently conflicted plan administrator without unduly raising insurance costs. *See Sandoval v. Aetna Life & Cas. Ins. Co.*, 967 F.2d 377, 380 (10th Cir. 1992) ("A primary goal of ERISA was to provide a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously.").

As applied to this case, there is no question that both an inherent conflict of interest and a serious procedural irregularity existed: UNUM conceded a conflict, but persistently resisted discovery as to the extent of that conflict. In addition, UNUM denied Ms. Fought's claim in a complicated set of circumstances without seeking any independent review.

Thus, when an inherent conflict of interest, or a serious procedural irregularity exists, such as here, and the plan administrator has denied coverage, the district court is required to slide along the scale considerably and an additional reduction in deference is appropriate.

Furthermore, application of this heightened standard of review does not contradict established law.[4] Under ERISA,

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[4] There is correlating line of authority which places the burden on the insurer to establish that the denial of benefits fell within the narrowly construed exclusionary clause. *See Caffey v. UNUM Life Ins. Co.*, 302 F.3d 576, 580 (6th Cir. 2002) ("ERISA places the burden of proving an exclusion from coverage in an ERISA-regulated welfare plan on the plan administrator."); *Frerking v. Blue Cross-Blue Shield of Kan.*, 760 F. Supp. 877, 881 (D. Kan. 1991) (noting that "[i]t is also well-established that the burden is upon the insurer to demonstrate that the insured's claim falls within the terms of the exclusionary clause, and that such clauses are interpreted narrowly") (citing *Tex. E. Transmission Corp. v. Marine Office-*

an insurer bears the burden to prove facts supporting an exclusion of coverage. *McGee v. Equicor-Equitable HCA Corp.*, 953 F.2d 1192, 1205 (10th Cir. 1992). Federal courts treat insurer claims of policy exclusions as affirmative defenses. *See* 5 CHARLES ALAN WRIGHT & ARTHUR R. MILLER, FEDERAL PRACTICE AND PROCEDURE: CIVIL 2D § 1271 (1990) ("[F]ederal courts have treated as [an] affirmative defense[] for purposes of Rule 8(c) . . . [a] claim by an insurer that the loss suffered by the insured was excepted by the policy's terms."). *See, e.g., Brownlow v. Aman*, 740 F.2d 1476, 1486-88 (10th Cir. 1984) (holding that a defendant must prove its affirmative defenses by a preponderance of the evidence); *Cleary v. Knapp Shoes, Inc.*, 924 F. Supp. 309, 315 (D. Mass. 1996) ("[A] plan administrator attempting to establish exclusion from coverage has the burden to establish by a preponderance of evidence that a covered employee's illness or medical condition is excludable.") (internal quotation marks omitted).

3. The district court's application of the standard of review

Here, the district court noted that UNUM had admitted its inherent conflict of interest. Aplt's App. at 12-13. The court then stated that it was "[f]ully recognizing" that conflict. *Id.* at 13. UNUM argues that the district court's use of the word "fully" in the order indicates that the district court engaged in the appropriate re-calibration along the sliding scale, while Ms. Fought argues that the district court did not reduce its deference in recognition of the conflict.

Appleton & Cox Corp., 579 F.2d 561, 564 (10th Cir. 1978) and *Milliken v. Fidelity & Cas. Co.*, 338 F.2d 35, 41 & n.13 (10th Cir. 1964)); *Cleary v. Knapp Shoes, Inc.*, 924 F. Supp. 309, 315 (D. Mass. 1996) (noting that "it is a general rule of insurance law that the insurer bears the burden of showing that a covered injury falls within an exclusion provision") (citing *McGee v. Equicor-Equitable HCA Corp.*, 953 F.2d 1192, 1205 (10th Cir. 1992)).

We certainly do not question the district court's awareness of a conflict. However, it is not completely clear how the district court's full "recognition" of the conflict of interest affected its review of the plan administrator's decision to deny benefits to Ms. Fought.

Immediately after recognizing the conflict, the district court provided the following description of its analysis: "[T]he guiding inquiry must be whether the plan administrator's decision was objectively reasonable given the administrative record–not whether a different reasonable decision could have been made." Aplt's App. at 13. This statement is difficult to distinguish from pure arbitrary and capricious deference:

> When reviewing under the arbitrary and capricious standard, [t]he Administrator['s] decision need not be the only logical one nor even the best one. It need only be sufficiently supported by facts within [his] knowledge to counter a claim that it was arbitrary or capricious. The decision will be upheld unless it is not grounded on *any* reasonable basis.

Kimber, 196 F.3d at 1098 (internal citations and quotation marks omitted). Notably, in *Kimber*, upon which the district court relied, *see* Aplt's App. at 13, the court had considered and rejected the possibility that the administrator's conflict of interest required it to slide away from the pure arbitrary and capricious standard. *See Kimber*, 196 F.3d at 1098 ("[T]here is insufficient evidence of a conflict of interest and review with deference is appropriate.").

The *Kimber* court's "reasonable basis" language, echoed by the district court here, is thus not the proper inquiry in this case. In *Kimber*, there was insufficient evidence of a conflict of interest. Here, the conflict was clear and uncontested. Under the standard we have set forth in this opinion, UNUM was required to justify its decision to exclude coverage by

substantial evidence. Under that standard, we now proceed to consider the district court's grant of summary judgment to UNUM. In so doing, we examine the language of the plan and the evidence on which UNUM relies in denying Ms. Fought's claims for benefits.

B. The Plan's Language

The policy at issue here, as noted above, includes the following language relevant to this appeal: "Your plan does not cover any disabilities caused by, contributed to by, or resulting from your . . . pre-existing condition." Aple's Supp. App. at 341-42.

> You have a pre-existing condition when you apply for coverage when you first become eligible if:
>
> —you received medical treatment, consultation, care or services including diagnostic measures or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; or you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the 3 months just prior to your effective date of coverage; and
>
> —the disability begins in the first 12 months after your effective date of coverage.

Id. at 342.

Applying our more searching and less deferential standard of review in light of UNUM's admitted conflict of interest, we must take a hard look and determine whether UNUM established by substantial evidence that Ms. Fought's claim was not covered by the plan.

> "We are mindful that the objective in construing a health care agreement, as with general contract terms, is to ascertain and carry out the true intention of the parties. However, we do so giving the language its common and

> ordinary meaning *as a reasonable person in the position of the [plan] participant*, not the actual participant, would have understood the words to mean."

Pitman, 217 F.3d at 1298 (quoting *Blair v. Metropolitan Life Ins. Co.*, 974 F.2d 1219, 1221 (10th Cir. 1992) (internal quotation marks omitted)).

1. The role of causation in interpreting the pre-existing condition clause

"Cause" means "[t]o be the cause of," which is "[s]omething that produces an effect, result, or consequence." WEBSTER'S II NEW RIVERSIDE UNIVERSITY DICTIONARY 239 (1988). "Contributed" is defined broadly as "[t]o act as a determining factor." *Id.* at 306. "Results" means "to happen or exist as a result of a cause." *Id.* at 1002.

Ms. Fought argues that UNUM impermissibly extended the language of the policy such that it excludes coverage for disabilities that result from surgery, not those that result from pre-existing conditions. The major difficulty presented by this case is that UNUM's policy excludes coverage *for disabilities caused* by pre-existing conditions, whereas it seeks here to apply its policy as if it excludes coverage for disabilities caused *by complications from surgery for pre-existing conditions*. Surgery is not, of course, a pre-existing condition, but at most a necessary consequence of a pre-existing condition. In essence, therefore, this case becomes a matter of where we draw the line on chains of causation.

UNUM responds that the broad language of the pre-existing condition dictates a similarly broad interpretation of the exclusion: the exclusion does not require that the disabling condition be the sole or direct result of the pre-existing condition. Here, UNUM applies the limitation because it believes the disabling condition was "caused by, contributed to, or resulted from" Ms. Fought's pre-existing condition. Based on the common ordinary meaning of the

terms "cause," "contribute," and "result," UNUM contends, the "exclusion merely requires that [Ms.] Fought's pre-existing heart condition be 'something' that brought about the disabling condition or that played a significant part in bringing about the disabling condition, or that the disabling condition arose as a consequence of the pre-existing condition." Aple's Br. at 25.

In practice, however, UNUM's arguments rely upon classic but/for causation: But for the coronary artery disease, none of the rest of the chain of events would have happened. Or, as Ms. Fought herself put it: "It is kind of like saying 'If I hadn't went outside in the rain, I wouldn't have got struck by lightening. [sic]'" Aplt's App. at 157 (Letter to New Mexico Public Relations Commission, dated Jan. 31, 2000).

As Ms. Fought persuasively argues, the chain of non-proximate causation that UNUM asserts in her case is attenuated to the point of absurdity:

> [UNUM's] argument necessarily goes something like this: but for the pre-existing coronary artery disease, Ms. Fought probably would not have the surgery; but for the surgery, Ms. Fought would not have had a surgical wound; but for the surgical wound, Ms. Fought's previously undetectable osteoporotic sternum would not have prevented her doctors from closing her wound in a more conventional manner, which might have given the wound greater stability and resistence to the lateral tension in the wound exerted by Ms. Fought's large breasts; but for the combination of the surgical wound, Ms. Fought's osteoporotic sternum and her large breasts, the wound probably would not have dehisced, thereby providing an entry point for the staph infection several weeks after the surgery; and, but for the fact that the staph infection was resistant to antibiotics, entered Ms.

> Fought's bloodstream, and eventually spread to other parts of her body, Ms. Fought would not be disabled.

Aplt's Br. at 21-22.

While the steps of causation are undoubtedly drawn out for effect, the larger point is a valid one. For Ms. Fought, there were at least five intervening stages between the pre-existing coronary artery disease and the disability: The failure of non-surgical alternatives, initially successful elective surgery, later complications from that surgery, initially successful treatment of those complications, and finally a drug resistant infection due to those complications, which in itself may have been caused by the intervening presence of Staphylococcus aureus due to faulty sterilization, sanitation, etc. UNUM seems to suggest that it need not cover anything for which it can construct a but/for story. If we were to accept this contention, we would effectively render meaningless the notion of the pre-existing condition clause by distending the breadth of the exclusion.

2. Department of Labor's regulations and example

The Department of Labor's regulations also undermine UNUM's interpretation of the plan. Those regulations provide the following example regarding the scope of a pre-existing condition exclusion:[5]

> Example 4. (i) Individual D, who is subject to a pre-existing exclusion imposed by Employer U's plan, has diabetes, as well as a foot condition caused by poor circulation and retinal degeneration (both of which are

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[5] Those regulations generally provide that "a group health plan, and a health insurance issuer offering group health insurance coverage, may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a) are satisfied." 29 C.F.R. § 2590.701-3(a)(i). Those regulations include the length of time during which the condition was treated and the kind of treatment that has been received for the condition. *See id.*

> conditions that may be directly attributed to diabetes). After enrolling in the plan, D stumbles and breaks a leg. (ii) In this Example 4, the leg fracture is not a condition related to D's diabetes, even though poor circulation in D's extremities and poor vision may have contributed towards the accident. However, any additional medical services that may be needed because of D's preexisting diabetic condition that would not be needed by another patient with a broken leg who does not have diabetes may be subject to the preexisting condition exclusion imposed under Employer U's plan.

29 C.F.R. § 2590.701-3 (a)(i)(C), Example 4.

In addition, the Practicing Law Institute provided these guidelines in interpreting § 2590.701-3:

> Thus, before imposing a preexisting condition limitation, plan sponsors must carefully evaluate whether a particular condition is "directly attributable" to the preexisting condition. Medical conditions which merely "contribute towards" accidents or illnesses, but are not "directly attributable" to the preexisting condition may not be excluded. This causal connection requirement will undoubtedly open the door for arguments that preexisting conditions were not the "proximate cause" of a particular injury or sickness—e.g., treatment of pneumonia for an individual who was previously diagnosed with AIDS.

John R. Hickman, *Insurance Law: What Every Lawyer and Businessperson Needs to Know*, HEALTH INSURANCE BASICS: ERISA, FMLA, ADA, ADEA, COBRA, HIPAA, AND PARCA, 584 PLI/Lit 413, 487 (May 1998).

When applying the above example from § 2590.701-3 to Ms. Fought's case, we determine that UNUM's expansive reading of the exclusion may be overly broad: The exclusion

cannot merely require that the pre-existing condition be one in a series of factors that contributes to the disabling condition; the disabling condition must be substantially or directly attributable to the pre-existing condition. *See also* WEBSTER'S II NEW RIVERSIDE DICTIONARY 306 (defining contribute as to mean "to act as a determining factor"). Ms. Fought's staph infection is not a condition related to her coronary artery disease, even though her unstable angina, which was related to her coronary artery disease, undoubtedly contributed to the need for surgery. To read the exclusion as broadly as UNUM, counters the essential tenets of contract law: Exclusions must be interpreted narrowly. *See* 29 C.F.R. § 2590.701-3 (a)(i)(C), Example 4 (applying narrow definition of "contributed towards"); *Frerking*, 760 F. Supp. at 881 (noting that in the context of plans governed by ERISA, "[i]t is also well-established that the burden is upon the insurer to demonstrate that the insured's claim falls within the terms of an exclusionary clause, and that such clauses are interpreted narrowly").

3. Illustrative cases

The few cases that have focused on the application of proximate cause to exclusions for pre-existing conditions are not inapposite. In *Cash v. Wal-Mart Group Health Plan*, 107 F.3d 637 (8th Cir. 1997), the plaintiff was diagnosed with diverticular disease. He later developed diverticulitis. The Eighth Circuit held the denial of benefits was reasonable, because the diverticulitis was a complication and secondary condition of the presence of diverticula in the wall of the colon. *Id.* at 643. In other words, the diverticular disease was a "necessary precursor" to the later illness of diverticulitis. *Id.* Here, in contrast, Ms. Fought's coronary condition was not a prerequisite to the onset of the staph infection: There is no necessary precursor link.

Similarly, in *Holsey v. UNUM Life Ins. Co. of Am.*, 944 F. Supp. 573, 579 (E.D. Mich. 1996), relied upon by the district

court, "[Plaintiff's] blindness was caused by, contributed to by or resulted from diabetes where blindness was related to diabetes and glaucoma was a well-known complication of diabetes; preexisting condition exclusion enforced." Aplt's App. at 14. *Holsey*, like *Cash*, clearly describes a situation where an insurer denied coverage for the *results* of diabetes, not for the complications from *treatment or surgery* for diabetes. Blindness certainly *is* a well-known complication of diabetes. Staph infections are *not*, so far as we are aware, a well-known complication of coronary artery disease.

The district court also cited to *Currie v. Metropolitan Life Ins. Co.*, No. CIV-A-1665, 1998 WL 214761, at *3-4 (E.D. La. April 29, 1998), and noted the *Currie* court "reject[ed the] argument that plaintiff was suffering from a different sickness or injury when she received treatment within the pre-existing period; all treatment stemmed from prior car wreck; pre-existing condition exclusion enforced." Aplt's App. at 14. The plaintiff in *Currie* was disabled because of back pain. She had been treated for back pain after a car accident that had occurred before she was covered by the insurance policy, so the insurer denied coverage for a pre-existing condition. She tried to claim that she was at that point suffering from a different kind of back pain, whereas the back pain for which she had received treatment was from a different cause; but the court held that all of the back pain had arisen from the car accident. This scenario, however, has nothing in common with Ms. Fought's case. The question is not whether her disability arose from a different surgery or a different form of heart disease but simply whether the causal connection between the disease and the disability is insufficiently proximate.

Next, in *Reinert v. Giorgio Foods, Inc.*, 15 F. Supp. 2d 589 (E.D. Pa. 1998), the plaintiff, Ms. Giorgio, suffered from three pre-existing conditions before she became eligible for plan benefits: diabetes, Charcot joint disease, and diabetic

neuropathy. She later suffered from a series of ulcerations on her left foot. Two of the ulcerations were manifestations of her pre-existing conditions. A third ulceration developed from an insulin needle that became embedded in the plaintiff's foot. The needle ulceration was a "separate and distinct injury which was aggravated by those underlying conditions." *Id.* The court found improper the denial of benefits for the treatment of this injury.

The court recognized, however, that the distinction between the ulcers was subtle. Ulcerations similar to those suffered by Ms. Giorgio were frequently caused by continuing deterioration of the bones and tissue in her foot, which was in turn caused by the diabetes, Charcot joint disease, and diabetic neuropathy. Thus, applying a strict arbitrary and capricious standard, with no conflict of interest present, the court determined that the improper denial of benefits as to the third ulcer was not arbitrary and capricious.

Here, UNUM cannot point to such nuances. The staph infection was a separate and distinct injury, not a manifestation of the underlying coronary disease.

Finally, and most importantly, in *Vander Pas v. UNUM Life Ins. Co. of Am.*, 7 F. Supp. 2d 1011 (E.D. Wisc. 1998), the plaintiff had suffered from a pre-existing heart condition for which he took the drug Coumadin. Coumadin puts a patient at risk for a subdural hematoma. The patient did suffer a subdural hematoma, and UNUM attempted to deny coverage on the theory that the pre-existing heart condition had caused him to take Coumadin, which had then caused the hematoma. The district court in *Vander Pas* described the chain of causality as "attenuated: [T]he plaintiff's atrial fibrillation caused him to take Coumadin, which brought about his subdural hematoma, which produced his disability." *Id.* at 1018. The court faulted UNUM for not providing a "proximate cause analysis," among other failings. *Id.* The district court therefore denied UNUM's motion for summary judgment.

UNUM attempts to distinguish *Vander Pas* by asserting that the court did not actually rule against UNUM on the basis of lack of proximate cause, but because UNUM "had not set forth **that, or any**, explanation of a chain of causation." Aple's Br. at 15 (bold-faced type in original). This misreads *Vander Pas*. The court clearly based its decision on UNUM's failure to explain how the treatment itself, Coumadin, was the "pre-existing condition." *Vander Pas*, 7 F. Supp. 2d at 1018. In other words, the district court properly required UNUM to show that the proximate cause of the disability (taking Coumadin) pre-existed. That the patient would not have been taking Coumadin but for the pre-existing heart condition did not make the pre-existing condition the "cause" of the disability. *See id.* ("[T]he proposition that Coumadin played a part in causing plaintiff's subdural hematoma . . . is not equivalent to a studied conclusion that plaintiff's use of Coumadin satisfies the definition for 'pre-existing condition,' or that his disability was 'caused by, contributed to by, or result[ed] from' the use of Coumadin."). Similarly here, UNUM must demonstrate that the proximate cause of the disability, here, the staph infection, was a pre-existing condition.

4. Availability of clearer language

Ms. Fought next argues that there is certainly a clearer way to write a contract that would exclude coverage for complications from surgery. Indeed, she notes a district court case from this circuit that considered a contract with precisely that language: "Pursuant to the Plan, long-term disability benefits . . . are not payable for any[] . . . [d]isability caused or contributed to by a Preexisting Condition *or medical or surgical treatment of a Preexisting Condition.*" *Kaus v. Standard Ins. Co.*, 985 F. Supp. 1277, 1279 (D. Kan. 1997) (emphasis added), *aff'd*, No. 97-3378, 1998 WL 778055 (10th Cir. Nov. 5, 1998); *see also Reinert*, 15 F. Supp. 2d at 595 (suggesting the redrafting of the exclusion to encompass "all

conditions relating to pre-existing illnesses" so as to avoid similar claims). In addition, the exclusion might be drafted to cover bacterial infections. *See, e.g., Lewin v. Metropolitan Life Ins. Co.*, 394 F.2d 608, 609 (3d Cir. 1968) (applying accident insurance policy). The district court acknowledged that the language "may be clearer in *Kaus*" but it reasoned that the contract language here is "broad enough to encompass the treatment received in this case." Aplt's App. at 15.

UNUM is a sophisticated party, and the plan's language is, on the whole, careful and thorough. The existence of policies, as in *Kaus*, that specifically deny coverage on the basis of complications from surgery lends support to the argument that it is unreasonable as a matter of law to conclude that the general language in Ms. Fought's contract encompasses the same result. UNUM had every opportunity to add the words "or medical or surgical treatment of a Preexisting Condition," *Kaus*, 985 F. Supp. at 1279, bu it did not do so. It is unreasonable to allow it to do so *post facto*, to the detriment of Ms. Fought and other insureds.

Given the Department's regulations invoking proximate cause, the illustration above, and the availability of clearer language, we conclude that the language of the exclusion provision in the contract should not be extended to the degree that UNUM attempts to do here. *See* 29 C.F.R. § 2590.701-3 (a)(i)(C), Example 4; *Frerking*, 760 F. Supp. at 881 (citing caselaw requiring a narrow interpretation of exclusion clauses).

C. Sufficiency of the evidence

Our inquiry does not end here, however. We still must determine whether the improper denial of benefits was supported by substantial evidence.

In denying disability benefits to Ms. Fought, UNUM relied in part on the discharge report presented by Dr. Waljii. Dr. Waljii's report indicated that, during the heart bypass surgery,

he discovered that Ms. Fought's sternum was "narrow and "very osteoporotic." Aplt's App. at 79. Dr. Waljii attempted to "reapproximate the sternum," using wires that tore through it. *Id.* He removed the wires and reapproximated the sternum using a surgical procedure called "Robichek reinforcement." *Id.* The remainder of the wound was closed in a "standard three layer closure." *Id.* He reported:

> Because of the large and pendulous breasts as well as significant adiposity, the lower portion of the skin incision was also at risk of dehiscence as indeed was the full sternum. Clearly her post-operative course was anticipated to be quite challenging given the concerns about the wound as indeed her other medical problems.

Id.

Ms. Fought returned to the hospital a few weeks later for "wound care of this sternal dehiscence and quite possibly sternal infection." Aplt's App. at 53. She was sent to a nursing facility a few days later. Approximately three weeks later she was readmitted because of increased wound pain. After two exposed sternal wires were detected, the methicillin-resistant Staphylococcus aureus infection was diagnosed in her bloodstream.

Ms. Fought's initial application for long term disability, filed in June 1999, while she was hospitalized, indicates that she was unable to work since the time of her open heart surgery. Her application's physician statement indicated that she had coronary artery disease, that she underwent bypass surgery, and that she continued to be hospitalized due to the sternal wound infection. As described above and as the medical records indicate, Ms. Fought was hospitalized for two months and underwent several operations and procedures as a result of the inability to clear up the staph infection.

UNUM's in-house pre-existing medical review concluded that the conditions were "most likely caused by, contributed

to, or resulted from [Ms. Fought's previously diagnosed severe hypertension and mod/severe left ventricle hypertrophy.]" Aplt's App. at 72. The in-house review took one day to complete and yielded a one-paragraph opinion that indicated that "[m]edical records from this period could further strengthen this opinion." *Id.* UNUM acknowledges that the staph infection was not present during the pre-existing time period, but that it resulted from the surgery "that was performed for a cardiac condition that was present . . . during that time frame." Aplt's App. at 147.

In support of her argument, Ms. Fought presents notes from three doctors indicating that the staph infection was a separate condition, unrelated to the coronary artery disease, without a preceding history. *See* Aplt's App. at 156. (Note from Dr. Robert T. Ferraro, dated Oct. 19, 1999) ("[T]he staph infection which is the basis for multiple wounds on chest its not related to coronary artery disease. This is a separate, unrelated diagnosis without preceding history."); *id.* at 154 (Note from Dr. Robert Dubroff, dated Oct. 22, 1999) ("[Ms.] Fought is totally disabled due to her heart condition. The staph infection was not a pre-existing condition."); *id.* at 155 (Note from Dr. Neil T. Chen, undated) ("[Ms.] Fought's chest and abdominal wounds/infection is [sic] *not* a pre-existing condition."). (emphasis in original). Two of the three physicians were treating physicians.

UNUM counters that the notes do not state that the staph infection caused her disabling condition, in fact, one note indicates that the disability was "due to her heart condition." *Id.* at 154. UNUM thus contends its reliance on the medical records, in conjunction with the medical notes, supports the plan administrator's conclusion that it was the coronary artery disease that set in motion the staph infection.

We acknowledge that, in some instances, the presence of conflicting evidence in the record may establish that a plan administrator's decision was reasonable. *See Sandoval*, 967

F.2d at 382. However, here, applying the less deferential standard, UNUM must establish by substantial evidence that its denial of benefits was reasonable. Moreover, the only arguably conflicting evidence here is the note from Dr. Dubroff that states both that Ms. Fought may be disabled "due to her heart condition" and that her "staph infection was not a pre-existing condition." Aplt's App. at 154. The bulk of Ms. Fought's medical records indicate that she was recovering well from the surgery; the onset of the staph infection, which originated from an unknown origin, was the debilitating condition. UNUM is unable to offer "more than a scintilla" of evidence, *Sandoval*, 967 F.2d at 382, that the staph infection was a manifestation of the pre-existing coronary artery condition, that it was caused by the pre-existing condition, or that it was substantially contributed to by or resulted from the pre-existing condition.

In addition, despite its apparent and admitted conflict of interest, UNUM undertook no independent evaluation or investigation. We note that, while not required, independent medical examinations are often helpful. Where a conflict of interest exists, the Seventh Circuit encourages, if not requires, such an inquiry: "When it is possible to question the fiduciaries' loyalty, they are obliged at a minimum to engage in an intensive and scrupulous independent investigation of their options to insure that they act in the best interests of the plan beneficiaries." *Hightshue v. AIG Life Ins. Co.*, 135 F.3d 1144, 1148 (7th Cir. 1998) (internal quotation marks omitted). "Seeking independent expert advice is evidence of a thorough investigation." *Id.; see also Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161 (8th Cir. 1998) (holding that administrator erred in failing to obtain an independent review of the claim by an expert when treating physician determined applicant was disabled and when there was evidence of an uncommon disease); *Morgan v. UNUM Life Ins. Co. of Am.*, 346 F.3d 1173, 1177 (8th Cir. 2003) (noting that "[i]n some circumstances, the administrator's use of an in-house

physician rather than a specialist to review a disability claim involving an uncommon disease can be a serious procedural irregularity affecting the administrator's decision"). Where, as here, a conflict of interest may impede the plan administrator's impartiality, the administrator best promotes the purposes of ERISA by obtaining an independent evaluation. *See* 29 U.S.C. § 1001(b).

In sum, we cannot say that, given UNUM's conflict of interest, and our sliding scale review, that UNUM has justified its denial of benefits by substantial evidence. UNUM's repeated denials of Ms. Fought's claims merely echo the terms of the pre-existing condition plan language, and offer at most thin support from the record before us.

III. CONCLUSION

We thus hold that the plan's language here does not reasonably apply to the attenuated chain of events between Ms. Fought's pre-existing coronary artery disease and her disabling staph infection and that UNUM's denial of benefits was not supported by substantial evidence. Accordingly, we REVERSE the district court's grant of summary judgment to UNUM and REMAND for further proceedings consistent with this opinion.[6]

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[6] Because we reverse the district court's grant of summary judgment in favor of UNUM, we also vacate the district court's order that UNUM recover its costs of action from Ms. Fought.

APPENDIX B

UNITED STATES COURT OF APPEALS
TENTH CIRCUIT

[Filed Feb. 6, 2004]

No. 02-2176

SHIRLEY O. FOUGHT,
Plaintiff-Appellant,

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Defendant-Appellee.

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEW MEXICO
(D.C. NO. CIV-01-124-PJK/LFG)

Robert P. Warburton (Ray M. Vargas, II, with him on the briefs), Sheehan, Sheehan & Stelzner, P.A., Albuquerque, New Mexico, for Plaintiff-Appellant.

Kathryn D. Lucero (Kerri L. Peck, with her on the brief), Foster, Johnson, McDonald, Lucero, Koinis, LLP, Albuquerque, New Mexico, for Defendant-Appellee.

Before TACHA, McKAY, and HENRY, Circuit Judges.

PER CURIAM.

Shirley O. Fought challenges the decision by UNUM's claims administrator to deny long-term disability benefits under her employer's group disability plan. A severe staph infection that followed elective heart surgery hospitalized and

disabled Ms. Fought. UNUM's plan administrator denied coverage by concluding that Ms. Fought suffered from a pre-existing coronary artery condition that "caused," "contributed to," or "resulted" in Ms. Fought's disability, citing language in the plan. After exhausting the company's internal appeals process, Ms. Fought brought a civil suit under 29 U.S.C. § 1132(a)(1)(B), alleging that she was entitled to disability benefits under the plan. UNUM admitted to a conflict of interest, as both payor and administrator of the plan. The magistrate judge denied discovery regarding the extent of UNUM's conflict of interest. The district court then granted summary judgment in favor of UNUM.

Exercising jurisdiction under 28 U.S.C. § 1291, we hold that the district court did not apply the appropriate standard of review when it considered the plan administrator's denial of benefits to Ms. Fought. Applying the correct standard of review, we reverse the grant of summary judgment in favor of UNUM and remand to the district court for further proceedings.

I. BACKGROUND

A. Undisputed Facts

On May 18, 1998, Ms. Fought enrolled in her employer's group long-term disability plan, which was issued by UNUM with an effective date of June 1, 1998. The policy, under a provision entitled "What disabilities are not covered under your plan?" states: "Your plan does not cover any disabilities caused by, contributed to by, or resulting from your . . . pre-existing condition." Aple's Supp. App. at 341-42.

The policy does not define the terms "caused by, contributed to by, or resulting from." The policy provides the following details regarding a pre-existing condition:

> You have a pre-existing condition when you apply for coverage when you first become eligible if:

> —you received medical treatment, consultation, care or services including diagnostic measure or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; or you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the 3 months just prior to your effective date of coverage; and
>
> —the disability begins in the first 12 months after your effective date of coverage.

Id. at 342.

Prior to her enrollment in the plan, Ms. Fought had been diagnosed and treated for coronary artery disease. In August 1998, approximately three months after her enrollment in the plan, Ms. Fought underwent angioplasty. On March 8, 1999, she was admitted for unstable angina syndrome, and on March 15, 1999, she underwent an elective coronary artery revascularization surgery. During surgery, the doctors discovered that Ms. Fought's sternum was narrow and osteoporotic, requiring a special procedure to close the surgical wound. Her doctors noted that "her postoperative course was anticipated to be quite challenging[,] given the concerns about the wound." Aplt's App. at 79. She was discharged six days after surgery on March 22, 1999. "At the time of [her] discharge, there [was] no evidence of infection," and "her wounds were healing well." *Id.* at 83; 166.

Three weeks later, the incision from Ms. Fought's wound became "dehisced," or split open. On April 8, 1999, she was readmitted for care of her dehisced sternal wound and a possible infection. Aple's Supp. App. at 97.

At this time, her wound cultures tested positive for a "few" Klebsiella pheumonia bacteria. She was placed on antibiotics and given intensive wound care to prevent infection. After a hospital stay of five days, and a "dramatic improvement in the appearance of the wound," she was sent to a skilled nursing facility. Aplt's App. at 85. At the time, the "wound

appearance looked satisfactory." *Id.* at 85. She was discharged from the facility on April 19, 1999.

On May 7, 1999, Ms. Fought complained of right-side chest pain. She was readmitted to the hospital on May 11, 1999, with a white blood cell count of 12,000 and a low grade fever. Two exposed sternal wires were detected. Her sternal wound and blood cultures were positive for both Klebsiella pneumonia and methicillin-resistant Staphylococcus aureus in the sternal wound and methicillin-resistant Staphylococcus aureus in the blood stream. *Id.* at 139.

Ms. Fought was placed in the Intensive Care Unit. Over the next two months, she underwent various operative procedures, was intubated, and received hemodyanmic monitoring, nutritional support, and sedation. One surgery involved extensive sternal wound reconstruction and required Ms. Fought to be placed on a ventilator. She was discharged on July 15, 1999, when she was transferred to another facility for intensive wound care.

On September 13, 1999, UNUM denied coverage under the long-term disability plan, having determined that Ms. Fought's pre-existing condition "caused, contributed to, or resulted in the condition(s) for which [she was] claiming disability." Aplt's App. at 33-34 (Letter to Ms. Fought from Anne Dionne, Disability Benefit Specialist, dated Sept. 13, 1999). Ms. Fought submitted a formal request to have her claim reopened, *see id.* at 143 (Letter from Ms. Fought to Ann Dionne, dated Oct. 19, 1999), as well as letters from three doctors certifying that the staph infection was neither a pre-existing condition nor related to her pre-existing coronary artery disease. *Id.* at 156 (Note from Dr. Robert T. Ferraro, dated Oct. 19, 1999) ("[T]he staph infection which is the basis for multiple wounds on chest is not related to coronary artery disease. *This is a separate, unrelated diagnosis without preceding history.*") (emphasis added); *id.* at 154 (Note from Dr. Robert Dubroff, dated Oct. 22, 1999) ("[Ms.] Fought is

totally disabled due to her heart condition. *The staph infection was not a pre-existing condition.*") (emphasis added); *id.* at 155 (Note from Dr. Neil T. Chen, undated) ("[Ms.] Fought's chest & abdominal wounds/infection is [sic] *not* a preexisting condition.") (emphasis in original). UNUM's medical department reviewed Dr. Ferraro's letter,[1] but the company declined to reverse its previous decision, stating that although "the staph infection itself was not present during the pre-existing condition period (3/1/98-5/31/98), it was the result of surgery that was performed for a cardiac condition that was present, diagnosed and treated during that time frame." *Id.* at 147-48 (Letter to Ms. Fought from Anne Dionne, dated Oct. 25, 1999).

Ms. Fought then retained legal counsel, who contacted UNUM's Long-Term Disability Quality Review Section, and informed the company that Ms. Fought was appealing the denial of coverage. *See id.* at 159. After a review, UNUM again denied coverage, stating that "the staph infection was

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[1] The letter from UNUM does not mention the other doctors' letters, saying only that "Dr. Ferraro's note was reviewed by our medical department." Aplt's App. at 147. Apparently, the other two doctors' letters were faxed to UNUM on October 25, 1999, the very day that UNUM sent Ms. Fought the letter confirming its denial of disability benefits. *See id.* at 146. "Plan administrators, of course, may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician." *Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965, 1972 (2003). We note that UNUM's subsequent review, *see* Aplt's App. at 150, appeared to include consideration of Ms. Fought's additional doctors' notes.

We also note that the parties do not argue that the plan administrator misallocated the weight it gave to the treating physician's opinion, so the admonishments of *Black & Decker* do not apply. *See Black & Decker*, 123 S. Ct. at 1972 ("[W]e hold [that] courts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant's physician; nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation.").

the result of surgery performed for a cardiac condition that was caused by, contributed to by, or resulted from the cardiac condition that was present, diagnosed and treated during the pre-existing period." *Id.* at 150 (Letter from John J. Schifano, Senior Benefit Analyst, dated Dec. 2, 1999).

Finally, Ms. Fought contacted the New Mexico Public Relations Commission, which corresponded with UNUM concerning Ms. Fought's situation. Responding to the state agency's inquiry, UNUM explained that the staph infection was the result of coronary bypass surgery, which was performed to treat her pre-existing condition. "She would not have had to have the surgery, later developing an infection, if she did not have the cardiac conditions which were present and treated for during the pre-existing period." *Id.* at 158 (Letter from Theresa-Ann Uminga, Senior Complaints Specialist, to James A. Chavez, Ms. Fought's Attorney, dated Feb. 11, 2000).

B. Procedural History

In August 2001, Ms. Fought filed suit in federal district court alleging UNUM violated 29 U.S.C. § 1132 in denying her claim for benefits. UNUM admitted that it operated under a conflict of interest, *id.* at 12 (Memorandum Opinion and Order Granting Defendant's Motion for Summary Judgment, filed May 31, 2002), because it both administers claims and is the payor of those claims. Ms. Fought requested discovery to allow inquiry into the extent of UNUM's conflict of interest. The magistrate judge denied this request.

UNUM moved for summary judgment. The district court, acknowledging the conflict of interest, proceeded to interpret the contract language "caused by, contributed to by, or resulting from" as meaning "related to" and "foreseeable complication of" a pre-existing condition. The district court ruled that the "staph infection [was] related to the coronary artery disease as a foreseeable complication of treatment." Aplt's

App. at 14. On that basis, the district court granted UNUM's motion for summary judgment, concluding that UNUM's decisions to deny Ms. Fought long-term disability benefits were not arbitrary or capricious, and ordered Ms. Fought to pay UNUM's costs.

Ms. Fought now appeals.

II. ANALYSIS

UNUM's long-term disability plan is governed by the Employee Retirement and Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.* "ERISA was enacted to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (citations and internal quotation marks omitted); *see also* 29 U.S.C. § 1001(b) ("It is hereby declared to be the policy of this chapter to protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans.").

In seeking coverage under her long-term disability benefit plan, Ms. Fought advances three arguments. First, she argues that the district court erred by using the wrong standard of review when it reviewed UNUM's decision. Second, she argues that UNUM's denial of benefits was, in any event, an unreasonable interpretation under the plan. Finally, she argues that the district court failed to consider UNUM's obligation to draft plan provisions in a manner calculated to be understood by the average plan participant.

We begin with the appropriate standard of review, discussing (1) the "sliding scale" standard of review, (2) the two-tier approach to determining how far we "slide" upon that "scale," and (3) the application of the reduced deference standard in this case.

We then combine our analysis of Ms. Fought's second and third arguments. Given our standard of review, we first analyze whether the plan administrator's construction of the plan language is a reasonable one. In so doing, we consider (a) the plan's pre-existing exclusion clause, (b) the role of causation in interpreting the pre-existing exclusion clause, (c) the Department of Labor's regulations and a published example regarding pre-existing conditions, (d) relevant circuit and district court case law involving similar questions, and (e) whether clearer exclusionary language may have been available to UNUM. Finally, we examine whether, given the record evidence and our reduced deference standard of review, UNUM's application of the pre-existing condition exclusion was supported by a preponderance of the evidence.

A. The Standard of Review

"Summary judgment orders are reviewed de novo, using the same standards as applied by the district court." *Pitman v. Blue Cross & Blue Shield of Okla*, 217 F.3d 1291, 1295 (10th Cir. 2000). Accordingly, like the district court, we must review UNUM's decision to deny benefits to Ms. Fought, and we must determine the appropriate standard to be applied.

The Supreme Court provided important guidance regarding the standard of review in ERISA benefits cases in *Firestone*, 489 U.S. at 113-15. The Court noted that deference to expert administrators is grounded in the most fundamental premises of trust law. If a disinterested party exercising discretionary powers has looked at evidence and rendered a decision, it is not only reasonable but a wise conservation of judicial resources not to have judges replicate the administrator's work. *See id.*

Recognizing that parties to a contract can agree to vest discretionary authority in an administrator, the Supreme Court held that "a denial of benefits challenged under § 1132(a)(1)(B) [ERISA] is to be reviewed under a de novo

standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115. There is no dispute that here the plan expressly gives UNUM, as plan administrator, the discretion to determine whether to deny a claimant insurance benefits under the plan. Aplt's. App. at 31. Therefore, because the plan grants UNUM discretion, "[a] court reviewing a challenge to a denial of employee benefits . . . applies an 'arbitrary and capricious' standard to a plan administrator's actions." *Charter Canyon Treatment Ctr. v. Pool Co.*, 153 F.3d 1132, 1135 (10th Cir. 1998). In reviewing a plan administrator's decision under the arbitrary and capricious standard, "the federal courts are limited to the 'administrative record'—the materials compiled by the administrator in the course of making his decision." *Hall v. UNUM Life Ins. Co. of Am.*, 300 F.3d 1197, 1201 (10th Cir. 2002).

The possibility of an administrator operating under a conflict of interest, however, changes the analysis. *Caldwell v. Life Ins. Co. of N. Am.*, 287 F.3d 1276, 1282 (10th Cir. 2002) ("Indicia of arbitrary and capricious decisions include . . . conflict of interest by the fiduciary."). Thus, "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion." *Firestone*, 489 U.S. at 115 (quoting RESTATEMENT (SECOND) OF TRUSTS § 187, cmt. d (1959)).[2]

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[2] We continue to treat the terms "arbitrary and capricious" and "abuse of discretion" as interchangeable in this context. *See Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 825 n.1 (10th Cir. 1996) ("Some circuit courts have recently distinguished between these two standards and have concluded that the abuse of discretion standard is more appropriate. Most courts, however, have held that this is a distinction without a difference. We agree and adhere to the arbitrary and capricious standard of review.") (internal citations and quotation marks omitted).

"The rationale for this approach is clear. A conflicted fiduciary may favor, consciously or unconsciously, its interests over the interests of the plan beneficiaries." *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556, 1565 (11th Cir. 1990); *see also Pitman*, 217 F.3d at 1296 ("'[W]hen an insurance company serves as ERISA fiduciary . . . , it is exercising discretion over a situation for which it incurs direct, immediate expense as a result of benefit determinations favorable to plan participants.'") (quoting *Brown*, 898 F.2d at 1561).

Following *Firestone*, the various circuit courts attempted to put the Court's instructions into practice. "Since *Firestone*, all of the circuit courts agree that a conflict of interest triggers a less deferential standard of review. The courts, however, differ over how this lesser degree of deference alters their review process." *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 825 (10th Cir. 1996).

1. Sliding Scale

In *Chambers*, we identified two basic approaches that had emerged in interpreting *Firestone*: the "sliding scale" approach and the "presumptively void" approach. We explicitly adopted the former. *Id.* at 826-27.

"Under [the sliding scale] approach, the reviewing court will always apply an arbitrary and capricious standard, but the court must decrease the level of deference given to the conflicted administrator's decision in proportion to the seriousness of the conflict." *Id.* at 825; *see also Ladd v. ITT Corp.*, 148 F.3d 753, 754 (7th Cir. 1998) (noting that when "the administrator has a conflict of interest, then, though the standard of review is nominally the same, the judicial inquiry is more searching"); *Spangler v. UNUM Life Ins. Co. of Am.*, 38 F. Supp. 2d 952, 955-56 (N.D. Okla. 1999) (noting that where conflict of interest is "apparent," further discovery is not required; "the court's review is a little more search-

ing . . . and the court is not as quick to defer to the administrator's discretion"). "[F]lexibility in the scope of judicial review need not require a proliferation of different standards of review; the arbitrary and capricious standard may be a range, not a point. There may be in effect a sliding scale of judicial review of trustees' decisions." *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052 (7th Cir. 1987); *Chambers*, 100 F.3d at 826 (quoting *Van Boxel* for same proposition). Therefore, we recognize that "the wholesale importation of the arbitrary and capricious standard into ERISA is unwarranted." *Firestone*, 489 U.S. at 109.

To say that there is a sliding scale of deference, however, merely begs the question: *how much* less deference ought a reviewing court afford? Our past opinions in this area do not clearly address this question. *See, e.g., McGraw v. Prudential Ins. Co. of Am.*, 137 F.3d 1253, 1258 (10th Cir. 1998) (recognizing the arbitrary and capricious standard as "inherently flexible" in that "the degree of deference . . . will be decreased on a sliding scale in proportion to the extent of conflict" without providing guidance as to what a deference reduction entails). Our failure to articulate clearly the requirements of a less deferential arbitrary and capricious standard has left district courts in this circuit without direction and has encouraged litigation.[3]

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[3] Our review of the law reveals a similar lack of direction from other circuits. *See, e.g., Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 390-93 (3d. Cir. 2000) (holding, without providing further guidance, that the deference accorded the fiduciary will be lessened by the degree necessary to neutralize influence resulting from conflict); *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 296 (5th Cir. 1999) (stating only that the "deference [provided to the administrator] will be lessened to the degree necessary to neutralize any untoward influence resulting from the conflict"); *Borda v. Hardy, Lewis, Pollard & Page, P.C.*, 138 F.3d 1062, 1069 (6th Cir. 1998) (concluding that the fiduciary will be entitled to some deference, but that "application of the standard should be shaped by

2. Defining the sliding scale: a two-tier approach

In light of this lack of clarity, we capitalize on this opportunity to elaborate more fully what a less deferential standard of review entails: We adopt the following two-tiered standard for reducing deference in instances in which a fiduciary has a conflict of interest because it (1) adheres to ERISA common law, (2) promotes sound public policy, and (3) provides clearer guidance to lower courts, lawyers, and potential litigants.

Under the first tier, in every case in which the plan administrator operates under a conflict of interest, the plan administrator bears the burden of proving the reasonableness of its decision pursuant to this court's traditional arbitrary and capricious standard. Under the second tier, the court must determine whether the conflict of interest at issue is so severe as to warrant an additional reduction in deference.

a. First tier

Under the first tier, "if a benefit plan gives discretion to an administrator . . . who is operating under a conflict of interest,

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the circumstances of the inherent conflict of interest"); *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 n.1 (7th Cir. 1998) (recognizing that "[t]he arbitrary and capricious standard does not pose an all-or-nothing choice between full deference or none"); *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161-62 (8th Cir. 1998) (describing the sliding scale as extremely flexible in that courts may adjust for all relevant circumstances). The Third Circuit states this well:

> We acknowledge that there is something intellectually unsatisfying, or at least discomforting, in describing our review as a "heightened arbitrary and capricious" standard. The locution is somewhat awkward. The routine legal meaning of an "arbitrary and capricious" decision is that used, quite understandably, by the district court: a decision "without reason, unsupported by substantial evidence or erroneous as a matter of law." Once the conflict becomes a "factor" however, it is not clear how the process required by the typical arbitrary and capricious review changes.

Pinto, 214 F.3d at 392.

that conflict must be weighed as a factor in determining whether there is an abuse of discretion." *Firestone*, 489 U.S. at 115 (internal quotations omitted). When reviewing a plan administrator's decision made under any conflict of interest, therefore, the reviewing court must afford the administrator less deference, *see id.*, without placing such an onerous burden on the administrator as to make voluntarily provided benefits cost prohibitive. *See* Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 Am. U.L. Rev. 1083, 1087-88 (2001) (hereinafter, Kennedy, *Judicial Standard*).

Professor Kennedy suggests a procedure for decreasing deference for first-tier cases that we find persuasive.

> [T]o further protect participants and beneficiaries in such conflict of interest contexts, [courts should] shift[] the burden to the fiduciary to justify the reasonableness of its decision. This puts the plan administrator on notice that its decisions will be judged for their reasonableness and provides the courts with a record that must show that the conflict of interest did not taint such decision. Such a result is still consistent with the *Firestone* admonition to consider as a factor any conflict of interest, but provides more direction for the courts in the application of the reasonableness standard.

Id. at 1174.

This burden shifting approach for first-tier cases has numerous advantages. First, it comports with our post-*Firestone* holdings that, even in cases of conflict of interest, the arbitrary and capricious standard provides the appropriate level of review. *See Chambers*, 100 F.3d at 827. Second, it provides clear direction to district courts, lawyers, and potential litigants. Third, it provides the less deferential review that we must accord a conflicted plan administrator without unduly raising insurance costs. *See Sandoval v. Aetna Life &*

Cas. Ins. Co., 967 F.2d 377, 380 (10th Cir. 1992) ("A primary goal of ERISA was to provide a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously."). Thus, in all cases in which a plan administrator acted while subject to a conflict of interest, the plan administrator should bear the burden to prove the reasonableness of its actions, pursuant to our arbitrary and capricious standard of review.

b. Second tier

While not every type of conflict of interest will require further deference reduction, our previous jurisprudence requires that we "decreas[e] the level of deference in proportion to the severity of the conflict." *Jones v. Kodak Med. Assistance Plan*, 169 F.3d 1287, 1291 (10th Cir. 1999). Thus, in certain types of cases merely shifting the burden ("first-tier" cases) will not adequately increase the level of judicial scrutiny in proportion to the severity of the conflict of interest. Therefore, in addition to shifting the burden of proof in all conflict cases, the reviewing court must grant even less deference to the plan administrator in those types of cases where a sufficiently serious conflict of interest exists ("second-tier" cases). *Cf. Chambers*, 100 F.3d at 827 ("[T]he arbitrary and capricious standard is sufficiently flexible to allow a reviewing court to adjust for the circumstances alleged, such as trustee bias in favor of a third-party or self-dealing by the trustee.") (quotation marks omitted).

In particular, when a plan administrator, who also serves as the third party insurer, has denied coverage, an additional reduction in deference is appropriate: the denial of coverage may be upheld only if the plan administrator/third party insurer establishes by a preponderance of the evidence that the denial is warranted. *See* Kennedy, *Judicial Standard*, 50 Am. U.L. Rev. at 1174 (commenting on the shifting of the burden of proof to fiduciaries with conflicts of interest). Although we need not determine every instance in which a

conflict of sufficient severity requires a further deference reduction, we do hold that such a sufficiently severe conflict exists where, as in the present case, the third-party insurer acts as the plan administrator and denies coverage for the insured.

We note that at least two other courts of appeals, in considering this type of conflict, suggest that UNUM does not face an especially serious conflict of interest and requires only a small reduction in deference. For instance, the Fifth Circuit states in dicta:

> When a minimal basis for a conflict is established, we review the decision with only a *modicum less* deference than we otherwise would. In the instant case, the district court held that UNUM had an "inherent conflict of interest" because it was both the insurer and the plan administrator, which determined whether to pay claims under the Policy. Accordingly, the district court found that UNUM's decision to deny Lain's claim was subject to a "modicum less deference."

Lain v. UNUM Life Ins. Co. of Am., 279 F.3d 337, 343 (5th Cir. 2002) (internal citations and some quotation marks omitted).

The Fourth Circuit suggests a similar approach:

> In cases like this one, when the plan administrator is also the plan's insurer, a conflict of interest exists. To safeguard against the potential for bias on the part of the insurer, a reviewing court must shift the standard of review to the extent necessary to counteract evidence of undue influence. We find virtually no evidence of self-dealing in the record, and therefore agree with the district court that the appropriate standard of review remains abuse of discretion, albeit with a concomitant

> skepticism of unsupported statements of UNUM representatives.

Jones v. UNUM Life Ins. Co. of Am., 57 Fed. Appx. 159, 160 (4th Cir. 2003) (unpublished) (citations omitted).

We find neither *Lain* nor *Jones* persuasive. Here, the plan administrator directly profits from the denial of claims, due to its dual position as third-party insurer and plan administrator. Indeed, UNUM faces a more severe conflict of interest than that facing other conflicted plan administrators because UNUM is not subject to countervailing pressures that work in favor of insureds. For instance, a reduced conflict of interest exists in cases in which the employer, or the employee's union, acts as the plan administrator, because they must balance their incentive to deny claims–and thus decrease premiums–with their desire to prevent declining employee morale, to retain skilled employees, and to mollify demands for wage increases. *See Smathers v. Multi-Tool, Inc./Multi-Plastics, Inc. Employee Health & Welfare Plan*, 298 F.3d 191, 197 (3d Cir. 2002) ("[T]he risk of a conflict of interest is decreased where the administrator and funder of the plan is the employer, rather than an insurance company, because the employer has incentives to avoid the loss of morale and higher wage demands that could result from denials of benefits.") (internal quotation marks omitted).

The serious nature of the conflict of interest faced by third-party insurer/plan administrators such as UNUM, "puts the plan administrator on notice that its decisions will be judged for their reasonableness and provides the courts with a record that must show that the conflict of interest did not taint such decision." Kennedy, *Judicial Standard*, at 1174. We thus modify our traditional arbitrary and capricious analysis in these cases to require support for the administrator's decision to deny coverage by a preponderance of the evidence, rather than the traditional requirement of substantial evidence. *Sandoval*, 967 F.2d at 380 n.4. Preponderance of the evidence

presents a higher standard of proof than substantial evidence. *Id.* at 382 (holding that substantial evidence "is such evidence that a reasonable mind might accept as adequate to support the conclusion reached by the [decisionmaker] . . . . [and] requires more than a scintilla but less than a preponderance") (internal quotation marks omitted).

Application of this heightened standard of review comports with established law.[4] Under ERISA, an insurer bears the burden to prove facts supporting an exclusion of coverage. *McGee v. Equicor-Equitable HCA Corp.*, 953 F.2d 1192, 1205 (10th Cir. 1992). Federal courts treat insurer claims of policy exclusions as affirmative defenses. *See* 5 CHARLES ALAN WRIGHT & ARTHUR R. MILLER, FEDERAL PRACTICE AND PROCEDURE: CIVIL 2D § 1271 (1990) ("[F]ederal courts have treated as [an] affirmative defense[] for purposes of Rule 8(c) . . . [a] claim by an insurer that the loss suffered by the insured was excepted by the policy's terms."). Thus, as an affirmative defense, an exclusion of coverage requires that the insurer provide proof by a preponderance of the evidence. *See, e.g., Brownlow v. Aman*, 740 F.2d 1476, 1486-88 (10th

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[4] There is correlating line of authority which places the burden on the insurer to establish that the denial of benefits fell within the narrowly construed exclusionary clause. *See Caffey v. UNUM Life Ins. Co.*, 302 F.3d 576, 580 (6th Cir. 2002) ("ERISA places the burden of proving an exclusion from coverage in an ERISA-regulated welfare plan on the plan administrator."); *Frerking v. Blue Cross-Blue Shield of Kan.*, 760 F. Supp. 877, 881 (D. Kan. 1991) (noting that "[i]t is also well-established that the burden is upon the insurer to demonstrate that the insured's claim falls within the terms of the exclusionary clause, and that such clauses are interpreted narrowly") (citing *Tex. E. Transmission Corp. v. Marine Office-Appleton & Cox Corp.*, 579 F.2d 561, 564 (10th Cir. 1978) and *Milliken v. Fidelity & Cas. Co.*, 338 F.2d 35, 41 & n.13 (10th Cir. 1964)); *Cleary v. Knapp Shoes, Inc.*, 924 F. Supp. 309, 315 (D. Mass. 1996) (noting that "it is a general rule of insurance law that the insurer bears the burden of showing that a covered injury falls within an exclusion provision") (citing *McGee v. Equicor-Equitable HCA Corp.*, 953 F.2d 1192, 1205 (10th Cir. 1992)).

Cir. 1984) (holding that a defendant must prove its affirmative defenses by a preponderance of the evidence); *Cleary v. Knapp Shoes, Inc.*, 924 F. Supp. 309, 315 (D. Mass. 1996) ("[A] plan administrator attempting to establish exclsion from coverage has the burden to establish by a preponderance of evidence that a covered employee's illness or medical condition is excludable.") (internal quotation marks omitted).

3. The district court's application of the standard of review

Here, the district court noted that UNUM had admitted its inherent conflict of interest. Aplt's App. at 12-13. The court then stated that it was "[f]ully recognizing" that conflict. *Id.* at 13. UNUM argues that the district court's use of the word "fully" in the order indicates that the district court engaged in the appropriate re-calibration along the sliding scale, while Ms. Fought argues that the district court did not reduce its deference in recognition of the conflict.

We certainly do not question the district court's awareness of a conflict. However, it is not completely clear how the district court's full "recognition" of the conflict of interest affected its review of the plan administrator's decision to deny benefits to Ms. Fought.

Immediately after recognizing the conflict, the district court provided the following description of its analysis: "[T]he guiding inquiry must be whether the plan administrator's decision was objectively reasonable given the administrative record—not whether a different reasonable decision could have been made." Aplt's App. at 13. This statement is difficult to distinguish from pure arbitrary and capricious deference:

> When reviewing under the arbitrary and capricious standard, [t]he Administrator['s] decision need not be the only logical one nor even the best one. It need only be sufficiently supported by facts within [his] knowledge

> to counter a claim that it was arbitrary or capricious. The decision will be upheld unless it is not grounded on *any* reasonable basis.

Kimber v. Thiokol Corp., 196 F.3d 1092, 1098 (10th Cir. 1999) (internal citations and quotation marks omitted). Notably, in *Kimber*, upon which the district court relied, *see* Aplt's App. at 13, the court had considered and rejected the possibility that the administrator's conflict of interest required it to slide away from the pure arbitrary and capricious standard. *See Kimber*, 196 F.3d at 1098 ("[T]here is insufficient evidence of a conflict of interest and review with deference is appropriate.").

The *Kimber* court's "reasonable basis" language, echoed by the district court here, is thus not the proper inquiry in this case. In *Kimber*, there was insufficient evidence of a conflict of interest. Here, the conflict was clear and uncontested. Under the standard we have set forth in this opinion, UNUM was required to justify its decision to exclude coverage by a preponderance of the evidence. Under that standard, we now proceed to consider the district court's grant of summary judgment to UNUM. In so doing, we examine the language of the plan and the evidence on which UNUM relies in denying Ms. Fought's claims for benefits.

B. The Plan's Language

The policy at issue here, as noted above, includes the following language relevant to this appeal: "Your plan does not cover any disabilities caused by, contributed to by, or resulting from your . . . pre-existing condition." Aple's Supp. App. at 341-42.

> You have a pre-existing condition when you apply for coverage when you first become eligible if:
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> —you received medical treatment, consultation, care or services including diagnostic measures or took prescrib-

> ed drugs or medicines in the 3 months just prior to your effective date of coverage; or you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the 3 months just prior to your effective date of coverage; and
>
> —the disability begins in the first 12 months after your effective date of coverage.

Id. at 342.

Applying our more searching and less deferential standard of review in light of UNUM's admitted conflict of interest, we must determine whether UNUM established by a preponderance of the evidence that Ms. Fought's claim was not covered by the plan.

> "We are mindful that the objective in construing a health care agreement, as with general contract terms, is to ascertain and carry out the true intention of the parties. However, we do so giving the language its common and ordinary meaning *as a reasonable person in the position of the [plan] participant*, not the actual participant, would have understood the words to mean."

Pitman, 217 F.3d at 1298 (quoting *Blair v. Metropolitan Life Ins. Co.*, 974 F.2d 1219, 1221 (10th Cir. 1992) (internal quotation marks omitted)).

1. The role of causation in interpreting the pre-existing condition clause

"Cause" means "[t]o be the cause of," which is "[s]omething that produces an effect, result, or consequence." WEBSTER'S II NEW RIVERSIDE UNIVERSITY DICTIONARY 239 (1988). "Contributed" is defined broadly as "[t]o act as a determining factor." *Id.* at 306. "Results" means "to happen or exist as a result of a cause." *Id.* at 1002.

Ms. Fought argues that UNUM impermissibly extended the language of the policy such that it excludes coverage for

disabilities that result from surgery, not those that result from pre-existing conditions. The major difficulty presented by this case is that UNUM's policy excludes coverage *for disabilities caused by* pre-existing conditions, whereas it seeks here to apply its policy as if it excludes coverage for disabilities caused by *complications from surgery for pre-existing conditions*. Surgery is not, of course, a pre-existing condition, but at most a necessary consequence of a pre-existing condition. In essence, therefore, this case becomes a matter of where we draw the line on chains of causation.

UNUM responds that the broad language of the pre-existing condition dictates a similarly broad interpretation of the exclusion: the exclusion does not require that the disabling condition be the sole or direct result of the pre-existing condition. Here, UNUM applies the limitation because it believes the disabling condition was "caused by, contributed to, or resulted from" Ms. Fought's pre-existing condition. Based on the common ordinary meaning of the terms "cause," "contribute," and "result," UNUM contends, the "exclusion merely requires that [Ms.] Fought's pre-existing heart condition be 'something' that brought about the disabling condition or that played a significant part in bringing about the disabling condition, or that the disabling condition arose as a consequence of the pre-existing condition." Aple's Br. at 25.

In practice, however, UNUM's arguments rely upon classic but/for causation: But for the coronary artery disease, none of the rest of the chain of events would have happened. Or, as Ms. Fought herself put it: "It is kind of like saying 'If I hadn't went outside in the rain, I wouldn't have got struck by lightening. [sic]'" Aplt's App. at 157 (Letter to New Mexico Public Relations Commission, dated Jan. 31, 2000).

As Ms. Fought persuasively argues, the chain of non-proximate causation that UNUM asserts in her case is attenuated to the point of absurdity:

> [UNUM's] argument necessarily goes something like this: but for the pre-existing coronary artery disease, Ms. Fought probably would not have the surgery; but for the surgery, Ms. Fought would not have had a surgical wound; but for the surgical wound, Ms. Fought's previously undetectable osteoporotic sternum would not have prevented her doctors from closing her wound in a more conventional manner, which might have given the wound greater stability and resistence to the lateral tension in the wound exerted by Ms. Fought's large breasts; but for the combination of the surgical wound, Ms. Fought's osteoporotic sternum and her large breasts, the wound probably would not have dehisced, thereby providing an entry point for the staph infection several weeks after the surgery; and, but for the fact that the staph infection was resistant to antibiotics, entered Ms. Fought's bloodstream, and eventually spread to other parts of her body, Ms. Fought would not be disabled.

Aplt's Br. at 21-22.

While the steps of causation are undoubtedly drawn out for effect, the larger point is a valid one. For Ms. Fought, there were at least five intervening stages between the pre-existing coronary artery disease and the disability: The failure of non-surgical alternatives, initially successful elective surgery, later complications from that surgery, initially successful treatment of those complications, and finally a drug resistant infection due to those complications, which in itself may have been caused by the intervening presence of Staphylococcus aureus due to faulty sterilization, sanitation, etc. UNUM seems to suggest that it need not cover anything for which it can construct a but/for story. If we were to accept this contention, we would effectively render meaningless the notion of the

pre-existing condition clause by distending the breadth of the exclusion.

2. Department of Labor's regulations and example

The Department of Labor's regulations also undermine UNUM's interpretation of the plan. Those regulations provide the following example regarding the scope of a pre-existing condition exclusion:[5]

> Example 4. (i) Individual D, who is subject to a preexisting exclusion imposed by Employer U's plan, has diabetes, as well as a foot condition caused by poor circulation and retinal degeneration (both of which are conditions that may be directly attributed to diabetes). After enrolling in the plan, D stumbles and breaks a leg. (ii) In this Example 4, the leg fracture is not a condition related to D's diabetes, even though poor circulation in D's extremities and poor vision may have contributed towards the accident. However, any additional medical services that may be needed because of D's preexisting diabetic condition that would not be needed by another patient with a broken leg who does not have diabetes may be subject to the preexisting condition exclusion imposed under Employer U's plan.

29 C.F.R. § 2590.701-3 (a)(i)(C), Example 4.

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[5] Those regulations generally provide that "a group health plan, and a health insurance issuer offering group health insurance coverage, may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a) are satisfied." 29 C.F.R. § 2590.701-3(a)(i). Those regulations include the length of time during which the condition was treated and the kind of treatment that has been received for the condition. *See id.*

In addition, the Practicing Law Institute provided these guidelines in interpreting § 2590.701-3:

> Thus, before imposing a preexisting condition limitation, plan sponsors must carefully evaluate whether a particular condition is "directly attributable" to the preexisting condition. Medical conditions which merely "contribute towards" accidents or illnesses, but are not "directly attributable" to the preexisting condition may not be excluded. This causal connection requirement will undoubtedly open the door for arguments that pre-existing conditions were not the "proximate cause" of a particular injury or sickness—e.g., treatment of pneumonia for an individual who was previously diagnosed with AIDS.

John R. Hickman, *Insurance Law: What Every Lawyer and Businessperson Needs to Know*, HEALTH INSURANCE BASICS: ERISA, FMLA, ADA, ADEA, COBRA, HIPAA, AND PARCA, 584 PLI/Lit 413, 487 (May 1998).

When applying the above example from § 2590.701-3 to Ms. Fought's case, we determine that UNUM's expansive reading of the exclusion may be overly broad: The exclusion cannot merely require that the pre-existing condition be one in a series of factors that contributes to the disabling condition; the disabling condition must be substantially or directly attributable to the pre-existing condition. *See also* WEBSTER'S II NEW RIVERSIDE DICTIONARY 306 (defining contribute as to mean "to act as a determining factor"). Ms. Fought's staph infection is not a condition related to her coronary artery disease, even though her unstable angina, which was related to her coronary artery disease, undoubtedly contributed to the need for surgery. To read the exclusion as broadly as UNUM, counters the essential tenets of contract law: Exclusions must be interpreted narrowly. *See* 29 C.F.R. § 2590.701-3 (a)(i)(C), Example 4 (applying narrow definition of "contributed towards"); *Frerking*, 760 F. Supp. at

881 (noting that in the context of plans governed by ERISA, "[i]t is also well-established that the burden is upon the insurer to demonstrate that the insured's claim falls within the terms of an exclusionary clause, and that such clauses are interpreted narrowly").

3. Illustrative cases

The few cases that have focused on the application of proximate cause to exclusions for pre-existing conditions are not inapposite. In *Cash v. Wal-Mart Group Health Plan*, 107 F.3d 637 (8th Cir. 1997), the plaintiff was diagnosed with diverticular disease. He later developed diverticulitis. The Eighth Circuit held the denial of benefits was reasonable, because the diverticulitis was a complication and secondary condition of the presence of diverticula in the wall of the colon. *Id.* at 643. In other words, the diverticular disease was a "necessary precursor" to the later illness of diverticulitis. *Id.* Here, in contrast, Mr. Fought's coronary condition was not a prerequisite to the onset of the staph infection: There is no necessary precursor link.

Similarly, in *Holsey v. UNUM Life Ins. Co. of Am.*, 944 F. Supp. 573, 579 (E.D. Mich. 1996), relied upon by the district court, "[Plaintiff's] blindness was caused by, contributed to by or resulted from diabetes where blindness was related to diabetes and glaucoma was a well-known complication of diabetes; preexisting condition exclusion enforced." Aplt's App. at 14. *Holsey*, like *Cash*, clearly describes a situation where an insurer denied coverage for the *results* of diabetes, not for the complications from *treatment or surgery* for diabetes. Blindness certainly *is* a well-known complication of diabetes. Staph infections are *not*, so far as we are aware, a well-known complication of coronary artery disease. The district court also cited to *Currie v. Metropolitan Life Ins. Co.*, No. CIV-A-1665, 1998 WL 214761, at *3-4 (E.D. La. April 29, 1998), and noted the *Currie* court "reject[ed the] argument that plaintiff was suffering from a different sickness

or injury when she received treatment within the pre-existing period; all treatment stemmed from prior car wreck; preexisting condition exclusion enforced." Aplt's App. at 14. The plaintiff in *Currie* was disabled because of back pain. She had been treated for back pain 'after a car accident that had occurred before she was covered by the insurance policy, so the insurer denied coverage for a pre-existing condition. She tried to claim that she was at that point suffering from a different kind of back pain, whereas the back pain for which she had received treatment was from a different cause; but the court held that all of the back pain had arisen from the car accident. This scenario, however, has nothing in common with Ms. Fought's case. The question is not whether her disability arose from a different surgery or a different form of heart disease but simply whether the causal connection between the disease and the disability is insufficiently proximate.

Next, in *Reinert v. Giorgio Foods, Inc.*, 15 F. Supp. 2d 589 (E.D. Pa. 1998), the plaintiff, Ms. Giorgio, suffered from three pre-existing conditions before she became eligible for plan benefits: diabetes, Charcot joint disease, and diabetic neuropathy. She later suffered from a series of ulcerations on her left foot. Two of the ulcerations were manifestations of her pre-existing conditions. A third ulceration developed from an insulin needle that became embedded in the plaintiff's foot. The needle ulceration was a "separate and distinct injury which was aggravated by those underlying conditions." *Id.* The court found improper the denial of benefits for the treatment of this injury.

The court recognized, however, that the distinction between the ulcers was subtle. Ulcerations similar to those suffered by Ms. Giorgio were frequently caused by continuing deterioration of the bones and tissue in her foot, which was in turn caused by the diabetes, Charcot joint disease, and diabetic neuropathy. Thus, applying a strict arbitrary and

capricious standard, with no conflict of interest present, the court determined that the improper denial of benefits as to the third ulcer was not arbitrary and capricious.

Here, UNUM cannot point to such nuances. The staph infection was a separate and distinct injury, not a manifestation of the underlying coronary disease.

Finally, and most importantly, in *Vander Pas v. UNUM Life Ins. Co. of Am.*, 7 F. Supp. 2d 1011 (E.D. Wisc. 1998), the plaintiff had suffered from a pre-existing heart condition for which he took the drug Coumadin. Coumadin puts a patient at risk for a subdural hematoma. The patient did suffer a subdural hematoma, and UNUM attempted to deny coverage on the theory that the pre-existing heart condition had caused him to take Coumadin, which had then caused the hematoma. The district court in *Vander Pas* described the chain of causality as "attenuated: [T]he plaintiff's atrial fibrillation caused him to take Coumadin, which brought about his subdural hematoma, which produced his disability." *Id.* at 1018. The court faulted UNUM for not providing a "proximate cause analysis," among other failings. *Id.* The district court therefore denied UNUM's motion for summary judgment.

UNUM attempts to distinguish *Vander Pas* by asserting that the court did not actually rule against UNUM on the basis of lack of proximate cause, but because UNUM "had not set forth **that, or any**, explanation of a chain of causation." Aple's Br. at 15 (bold-faced type in original). This misreads *Vander Pas*. The court clearly based its decision on UNUM's failure to explain how the treatment itself, Coumadin, was the "pre-existing condition." *Vander Pas*, 7 F. Supp. 2d at 1018. In other words, the district court properly required UNUM to show that the proximate cause of the disability (taking Coumadin) pre-existed. That the patient would not have been taking Coumadin but for the pre-existing heart condition did not make the pre-existing

condition the "cause" of the disability. *See id.* ("[T]he proposition that Coumadin played a part in causing plaintiff's subdural hematoma . . . is not equivalent to a studied conclusion that plaintiff's use of Coumadin satisfies the definition for 'pre-existing condition,' or that his disability was 'caused by, contributed to by, or result[ed] from' the use of Coumadin."). Similarly here, UNUM must demonstrate that the proximate cause of the disability, here, the staph infection, was a pre-existing condition.

4. Availability of clearer language

Ms. Fought next argues that there is certainly a clearer way to write a contract that would exclude coverage for complications from surgery. Indeed, she notes a district court case from this circuit that considered a contract with precisely that language: "Pursuant to the Plan, long-term disability benefits . . . are not payable for any[] . . . [d]isability caused or contributed to by a Preexisting Condition or *medical or surgical treatment of a Preexisting Condition*." *Kaus v. Standard Ins. Co.*, 985 F. Supp. 1277, 1279 (D. Kan. 1997) (emphasis added), *aff'd*, No. 97-3378, 1998 WL 778055 (10th Cir. Nov. 5, 1998); *see also Reinert*, 15 F. Supp. 2d at 595 (suggesting the redrafting of the exclusion to encompass "all conditions relating to pre-existing illnesses" so as to avoid similar claims). In addition, the exclusion might be drafted to cover bacterial infections. *See, e.g., Lewin v. Metropolitan Life Ins. Co.*, 394 F.2d 608, 609 (3d Cir. 1968) (applying accident insurance policy). The district court acknowledged that the language "may be clearer in *Kaus*" but it reasoned that the contract language here is "broad enough to encompass the treatment received in this case." Aplt's App. at 15.

UNUM is a sophisticated party, and the plan's language is, on the whole, careful and thorough. The existence of policies, as in *Kaus*, that specifically deny coverage on the basis of complications from surgery lends support to the argument

that it is unreasonable as a matter of law to conclude that the general language in Ms. Fought's contract encompasses the same result. UNUM had every opportunity to add the words "or medical or surgical treatment of a Preexisting Condition," *Kaus*, 985 F. Supp. at 1279, but it did not do so. It is unreasonable to allow it to do so *post facto*, to the detriment of Ms. Fought and other insureds.

Given the Department's regulations invoking proximate cause, the illustration above, and the availability of clearer language, we conclude that the language of the exclusion provision in the contract should not be extended to the degree that UNUM attempts to do here. See 29 C.F.R. § 2590.701-3 (a)(i)(C), Example 4; *Frerking*, 760 F. Supp. at 881 (citing caselaw requiring a narrow interpretation of exclusion clauses).

C. Sufficiency of the evidence

Our inquiry does not end here, however. We still must determine whether the improper denial of benefits was supported by a preponderance of the evidence.

In denying disability benefits to Ms. Fought, UNUM relied in part on the discharge report presented by Dr. Waljii. Dr. Waljii's report indicated that, during the heart bypass surgery, he discovered that Ms. Fought's sternum was "narrow and "very osteoporotic." Aplt's App. at 79. Dr. Waljii attempted to "reapproximate the sternum," using wires that tore through it. *Id.* He removed the wires and reapproximated the sternum using a surgical procedure called "Robichek reinforcement." *Id.* The remainder of the wound was closed in a "standard three layer closure." *Id.* He reported:

> Because of the large and pendulous breasts as well as significant adiposity, the lower portion of the skin incision was also at risk of dehiscence as indeed was the full sternum. Clearly her post-operative course was

> anticipated to be quite challenging given the concerns about the wound as indeed her other medical problems.

Id.

Ms. Fought returned to the hospital a few weeks later for "wound care of this sternal dehiscence and quite possibly sternal infection." Aplt's App. at 53. She was sent to a nursing facility a few days later. Approximately three weeks later she was readmitted because of increased wound pain. After two exposed sternal wires were detected, the methicillin-resistant Staphylococcus aureus infection was diagnosed in her bloodstream.

Ms. Fought's initial application for long term disability, filed in June 1999, while she was hospitalized, indicates that she was unable to work since the time of her open heart surgery. Her application's physician statement indicated that she had coronary artery disease, that she underwent bypass surgery, and that she continued to be hospitalized due to the sternal wound infection. As described above and as the medical records indicate, Ms. Fought was hospitalized for two months and underwent several operations and procedures as a result of the inability to clear up the staph infection.

UNUM's in-house pre-existing medical review concluded that the conditions were "most likely caused by, contributed to, or resulted from [Ms. Fought's previously diagnosed severe hypertension and mod/severe left ventricle hypertrophy.]" Aplt's App. at 72. The in-house review took one day to complete and yielded a one-paragraph opinion that indicated that "[m]edical records from this period could further strengthen this opinion." *Id.* UNUM acknowledges that the staph infection was not present during the pre-existing time period, but that it resulted from the surgery "that was performed for a cardiac condition that was present . . . during that time frame." Aplt's App. at 147.

In support of her argument, Ms. Fought presents notes from three doctors indicating that the staph infection was a

separate condition, unrelated to the coronary artery disease, without a preceding history. *See* Aplt's App. at 156. (Note from Dr. Robert T. Ferraro, dated Oct. 19, 1999) ("[T]he staph infection which is the basis for multiple wounds on chest is not related to coronary artery disease. This is a separate, unrelated diagnosis without preceding history."); *id.* at 154 (Note from Dr. Robert Dubroff, dated Oct. 22, 1999) ("[Ms.] Fought is totally disabled due to her heart condition. The staph infection was not a pre-existing condition."); *id.* at 155 (Note from Dr. Neil T. Chen, undated) ("[Ms.] Fought's chest and abdominal wounds/infection is [sic] *not* a pre-existing condition."). (emphasis in original). Two of the three physicians were treating physicians.

UNUM counters that the notes do not state that the staph infection caused her disabling condition, in fact, one note indicates that the disability was "due to her heart condition." *Id.* at 154. UNUM thus contends its reliance on the medical records, in conjunction with the medical notes, supports the plan administrator's conclusion that it was the coronary artery disease that set in motion the staph infection.

We acknowledge that, in some instances, the presence of conflicting evidence in the record may establish that a plan administrator's decision was reasonable. *See Sandoval*, 967 F.2d at 382. However, here, applying the new standard, UNUM must establish by a preponderance of the evidence that its denial of benefits was warranted by the plan language and the evidence. Moreover, the only arguably conflicting evidence here is the note from Dr. Dubroff that states both that Ms. Fought may be disabled "due to her heart condition" and that her "staph infection was not a pre-existing condition." Aplt's App. at 154. The bulk of Ms. Fought's medical records indicate that she was recovering well from the surgery; the onset of the staph infection, which originated from an unknown origin, was the debilitating condition. UNUM is unable to offer "more than a scintilla" of evidence,

Sandoval, 967 F.2d at 382, that the staph infection was a manifestation of the pre-existing coronary artery condition, that it was caused by the pre-existing condition, or that it was substantially contributed to by or resulted from the pre-existing condition.

In addition, despite its apparent and admitted conflict of interest, UNUM undertook no independent evaluation or investigation. We note that, while not required, independent medical examinations are often helpful. Where a conflict of interest exists, the Seventh Circuit encourages, if not requires, such an inquiry: "When it is possible to question the fiduciaries' loyalty, they are obliged at a minimum to engage in an intensive and scrupulous independent investigation of their options to insure that they act in the best interests of the plan beneficiaries." *Hightshue v. AIG Life Ins. Co.*, 135 F.3d 1144, 1148 (7th Cir. 1998) (internal quotation marks omitted). "Seeking independent expert advice is evidence of a thorough investigation." *Id.*; *see also Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161 (8th Cir. 1998) (holding that administrator erred in failing to obtain an independent review of the claim by an expert when treating physician determined applicant was disabled and when here was evidence of an uncommon disease). Where, as here, a conflict of interest may impede the plan administrator's impartiality, the administrator best promotes the purposes of ERISA by obtaining an independent evaluation. *See* 29 U.S.C. § 1001(b).

In sum, we cannot say that, given UNUM's conflict of interest, and our modified sliding scale review, that UNUM has justified its denial of benefits by a preponderance of the evidence. UNUM's repeated denials of Ms. Fought's claims merely echo the terms of the pre-existing condition plan language, and offer at most thin support from the record before us.

III. CONCLUSION

We thus hold that the plan's language here does not reasonably apply to the attenuated chain of events between Ms. Fought's pre-existing coronary artery disease and her disabling staph infection and that UNUM's denial of benefits was not supported by a preponderance of the evidence. Accordingly, we REVERSE the district court's grant of summary judgment to UNUM and REMAND for further proceedings consistent with this opinion.[6]

[6] Because we reverse the district court's grant of summary judgment in favor of UNUM, we also vacate the district court's order that UNUM recover its costs of action from Ms. Fought.

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

[Filed August 13, 2004]

No. 02-2176

SHIRLEY O. FOUGHT,
Plaintiff-Appellant,

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Defendant-Appellee.

ORDER

Before TACHA, *Chief Judge*, McKAY, and HENRY, *Circuit Judges*.

This matter is before the court on appellee's Petition For Rehearing and Suggestion for Rehearing En Banc. The request for panel rehearing is granted. The per curiam opinion filed on February 6, 2004 is vacated, and the attached revised opinion is substituted in its place.

In light of the substantial revisions made by the panel, however, we will suspend local rule 40.3, which prohibits successive rehearing petitions. *See* Fed. R. App. P. 2 (giving court of appeals discretion, for good cause, to "suspend any provision of [the] rules"); 10th Cir. R. 2.1 (providing court discretion to suspend the local rules).

Entered for the Court

PATRICK FISHER, Clerk of Court

by: [ILLEGIBLE]
Deputy Clerk

APPENDIX D

UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

Filed August 13, 2004

No. 02-2176

SHIRLEY O. FOUGHT,
Plaintiff-Appellant,

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Defendant-Appellee.

ORDER

Before TACHA, *Chief Judge*, SEYMOUR, EBEL, HENRY, BRISCOE, LUCERO, MURPHY, HARTZ, O'BRIEN, MCCONNELL and TYMKOVICH, *Circuit Judges*[*].

This matter is before the court on appellee's Petition For Rehearing and Suggestion for Rehearing En Banc. The suggestion for rehearing en banc was transmitted to all of the judges of the court who are in regular active service. A poll was requested and a majority of the active judges voted to deny rehearing en banc. Judge Murphy would grant rehearing en banc.

In light of the substantial revisions made by the panel in this matter, however, we will suspend local rule 35.1(C), which prohibits reconsideration of the denial of en banc rehearing. *See* Fed. R. App. P. 2 (giving court of appeals discretion, for

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[*] The Honorable Paul J. Kelly is recused in this matter.

good cause, to "suspend any provision of [the] rules"); *see also* 10th Cir. R. 2.1 (providing court discretion to suspend the local rules). Either party may, within 14 days of the date of this order, file a petition for rehearing en banc of the substituted opinion filed on August 13, 2004. Any en banc petition must comply with all the requirements found in Federal Rule of Appellate Procedure 35 and local rules 35.2 and 35.4.

Entered for the Court
PATRICK FISHER, Clerk of Court

by: [ILLEGIBLE]
Deputy Clerk

APPENDIX E

UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

[Filed October 26, 2004]

No. 02-2176

SHIRLEY O. FOUGHT,
Plaintiff - Appellant,

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Defendant - Appellee.

ORDER

Before TACHA, *Chief Circuit Judge*, McKAY and HENRY, *Circuit Judges*.

Appellee's petition for rehearing is denied.

The petition for rehearing en banc was transmitted to all of the judges of the court who are in regular active service. As no member of the panel and no judge in regular active service on the court requested that the court be polled, that petition is also denied.

Entered for the Court

PATRICK FISHER, Clerk of Court

by: [ILLEGIBLE]
Deputy Clerk

APPENDIX F

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

No. CIV 01-0124 PK/JHG (ACE)

SHIRLEY O. FOUGHT,

Plaintiff,

vs.

UNUM LIFE INSURANCE COMPANY OF AMERICA,

Defendant.

MEMORANDUM OPINION AND ORDER

THIS MATTER comes on for consideration of Defendant's ["UNUM's"] Motion for Summary Judgment filed March 10, 2002 (Doc. 33). Upon consideration thereof,

(1) *Background.* This case involves a plan administrator's denial of disability benefits under a group long-term disability insurance policy issued by UNUM to Ms. Fought's employer as part of an employee benefit plan. Ms. Fought enrolled in the plan on May 18, 1998. The effective date of the policy was June 1, 1998. In her amended complaint, Ms. Fought has claims for disability benefits, 29 U.S.C. § 1132(a)(1)(B), and for breach of fiduciary duty, 29 U.S.C. § 1132(a)(2), (3). The court agrees with UNUM that the breach of fiduciary duty claim is duplicative of the claim for benefits, and that the latter is exclusive in these circumstances. *See Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996); *Montesano v. Xerox Corp.*, 256 F.3d 86, 88 (2d Cir. 2001); *McCall v., Burlington N./Santa Fe Co.*, 237 F.3d 506, 512 (5th Cir. 2000), cert. *denied*, 122 S. Ct. 57 (2001); *see also Moore v.*

Berg, Enter. Inc., No. 98-4080, 1999 WL 1063823, *2 n.3 (10th Cir. Nov. 23, 1999).

(2) *Ms. Fought's Health Conditions.* Prior to enrolling in the plan, Ms. Fought had been diagnosed with severe coronary artery disease. In August 1998, she underwent angioplasty. In March 1999, Ms. Fought underwent heart by-pass surgery. During the operation, Ms. Fought's surgeon discovered that Ms. Fought's sternum (breastbone) was quite narrow and showed signed of osteoporosis (reduction in bone mass). In his initial attempt to reapproximate the sternum, the surgeon reported that the wires used started tearing through the sternum. UFOU-396. He removed them and then used a special procedure (Robichek procedure) to wire the sternum back together before closing the incision. He reported:

> Because of the large and pendulous breasts as well as significant adiposity, the lower portion of the skin incision was also at risk of dehiscence [splitting open] as indeed was the full sternum. Clearly her postoperative course was anticipated to be quite challenging given the concerns about the wound as indeed her other medical problems.

Ms. Fought's discharge report indicated that "[t]here is some concern in regard to her sternal incision site due to her obesity," but there was no evidence of infection. UFOU-410. Unfortunately, a few weeks after surgery, the surgical incision above Ms. Fought's sternum dehisced. She was admitted to the hospital "for wound care of this sternal dehiscence and quite possibly sternal infection." UFOU-275; *see also* UFOU-274 (identifying "several risk factors for sternal wound dehiscence and infection"). Ms. Fought subsequently developed a severe staph infection at the site of the incision. UFOU-490. She cannot return to work.

(3) *Policy Pro*visions. The policy contained an exclusion based upon pre-existing conditions:

> WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?
>
> Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:
>
> . . . .
>
> —pre-existing condition
>
> . . . .
>
> WHAT IS A PRE-EXISTING CONDITION?
>
> You have a pre-existing condition when you apply for coverage when you first become eligible if:
>
> —you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; or you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the 3 months just prior to your effective date of coverage; and
>
> —the disability begins in the first 12 months after your effective date of coverage.

UFOU-13 to 14. Thus, the pre-existing condition exclusion ran from March 1, 1998 (three months prior to the June 1, 1998, effective date of coverage), to May 31, 1999 (the first twelve months after the June 1, 1998, effective date of the coverage) if the first condition was satisfied.

(4) *UNUM's Denial of Ms. Fought's Claims and Subsequent Appeals*. The initial claim for benefits on behalf of Ms. Fought was submitted in June 1999. It reported that Ms. Fought's first symptoms were chest pain occurring on March 9, 1999 and that she was unable to work due to open

heart surgery. UFOU-198. This was corroborated by information supplied by the employer. UFOU-183, 185. UNUM relied upon the pre-existing condition exclusion. It denied the claim on the grounds that Ms. Fought was treated on March 16, 1998, and diagnosed with various conditions,[1] including her cardiac condition, that "caused, contributed to, or resulted in the condition(s) for which you are now claiming disability." UFOU-107; *see also* UFOU-343. Ms. Fought appealed and submitted a note from her treating physician "that the staph infection which is the basis for multiple wounds on the chest is not related to coronary artery disease. This is a separate, unrelated diagnosis without preceding history." UFOU-499. UNUM affirmed its denial of the claim on the same grounds explaining "that the staph infection was the result of surgery performed for a cardiac condition that was caused by, contributed to by, or resulted from the cardiac condition that was present, diagnosed and treated during the pre-existing period." UFOU-535. Ms. Fought appealed again on the theory that the staph infection was not pre-existing and submitted notes from her doctors that the staph infection was not a pre-existing condition. UFOU-544. UNUM reaffirmed its denial reasoning that "the staph infection is caused by, contributed to by, or related to the CAD [coronary artery disease] as she would not have had the surgery + the resultant wound infection if she did not have the CAD which was being treated by the surgery." UFOU-577 to 578.

(5) *Summary Judgment Standard.* Summary judgment is appropriate when "there is no genuine issue as to any material fact and . . . the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). A movant is responsible for identifying the basis of its motion, which it may support with material demonstrating the absence of a genuine issue of

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[1] Those conditions were "poorly controlled systemic hypertension, severe left ventricular hypertrophy with abnormal diastolic function, and possible left ventricular hypertrophy." UFOU-107

material fact. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). Here, UNUM as the movant relies upon the administrative record which is appropriate because it contains the evidence and arguments before the decision maker. *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 823-24 (10th Cir. 1996); *Sandoval v. Aetna Life & Cas. Ins. Co.*, 967 F.2d 377, 380 (10th Cir. 1992). In opposing a summary judgment motion, the non-movant may not rest upon her pleadings, but "must set forth specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e). Here, Ms. Fought also relies upon the administrative record, a medical record and her own affidavit. It is doubtful that the items outside the record should be considered; regardless, even considering them, summary judgment in favor of UNUM is warranted.

A court considers all evidence and reasonable inferences therefrom in the light most favorable to the non-movant; however, that material must contain probative evidence that would allow a trier of fact to find in favor of the non-movant. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249-50 (1986). Disputes about immaterial facts will not preclude summary judgment. *Id.* at 248.

(6) *Abuse of Discretion Standard for Review of the Administrator's Denial of Benefits*. The policy provides that UNUM had discretion to determine eligibility for benefits and to interpret the plan. UFOU-26. Accordingly, UNUM's denial of benefits falls under the "abuse of discretion" standard. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). In the Tenth Circuit, "[i]ndicia of arbitrary and capricious decisions include lack of substantial evidence, mistake of law, bad faith and conflict of interest by the fiduciary." *Caldwell v. Life Ins. Co. of N. Am.*, 287 F.3d 1276, 1282 (10th Cir. 2002). Because UNUM as an insurer is both the claims administrator and the payor, a sliding scale abuse of discretion standard applies recognizing UNUM's inherent conflict of interest. *See id.; Pitman v. Blue Cross & Blue*

Shield of Okla., 217 F.3d 1291, 1296-97 (10th Cir. 2000); *see also* Doc. 28 at 4 (UNUM conceding that it has an inherent conflict of interest to which a sliding scale abuse of discretion standard should apply). Ms. Fought argues that the sliding scale should be weighed heavily against UNUM because it is a for-profit insurer that drafted the policy provision in question and its interpretation is tainted by its conflict of interest. Her argument rests in part on the doctrine of contra proferentem (ambiguous terms are construed against the drafter), which is inapplicable when benefit denials under ERISA plans are reviewed for an abuse of discretion. *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1100-01 (10th Cir. 1999). Fully recognizing UNUM's conflict of interest, the guiding inquiry must be whether the plan administrator's decision was objectively reasonable given the administrative record–not whether a different reasonable decision could have been made.

(7) *UNUM Did Not Abuse Its Discretion in Denying Benefits.* Applying that standard, UNUM did not abuse its discretion in denying benefits for the reason that Ms. Fought's disability (staph infection) was "caused by, contributed to by, or resulting from" her cardiac problems that occurred during the pre-existing period. There is no dispute that Ms. Fought's cardiac condition was a pre-existing condition. Ms. Fought's argument is that because the dehiscence of her sternal wound occurred weeks after her surgery and thereafter she tested positive for staph, the claims administrator was required to view the cardiac condition as separate and distinct from the staph infection (and her resultant inability to work). Doc. 37 at 2-3. However, the disabling condition and pre-existing condition need not be identical; otherwise, the expansive language "caused by, contributed to by, or resulting from" would be superfluous. Nor is a claims administrator required to have evidence in the record that coronary artery disease causes staph infection; rather, the course of treatment resulting from the coronary artery disease

may be considered. Here, the staph infection is related to the coronary artery disease as a foreseeable complication of treatment. *See Holsey v. UNUM Life Ins. Co.*, 944 F. Supp. 573, 579 (E.D. Mich. 1996) (blindness was caused by, contributed to by or resulted from diabetes where blindness was related to diabetes and glaucoma was a well-known complication of diabetes; preexisting condition exclusion enforced)[2]; *see also Currie v., Metropolitan Life Ins. Co.*, No. CIV. A. 97-1665, 1998 WL 214761 at * 3-4 (E.D. La. April 29, 1998) (rejecting argument that plaintiff was suffering from a different sickness or injury when she received treatment within the pre-existing period; all treatment stemmed from a prior car wreck; preexisting condition exclusion enforced).

(8) She also argues that had UNUM wanted to exclude medical or surgical treatment of a pre-existing condition from coverage, as opposed to excluding the pre-existing condition itself, UNUM should have done so. She relies upon *Kaus v. Standard Ins.*, 985 F. Supp. 1277, 1279 (D. Kan. 1997), *aff'd*, 162 F.3d 1173, No. 97-3378, 1998 WL 778055 (10th Cir. Nov. 5, 1998), where the pre-existing condition exclusion included "medical or surgical treatment of a Preexisting Condition." While the exclusion may be clearer in *Kaus*, the language "caused by, contributed to by, or resulting from" a pre-existing condition is broad enough to encompass the treatment received in this case.

She also points out that UNUM's interpretation leads to absurd results, "the exclusion would operate to exclude coverage for disabilities caused by such things as allergic

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[2] Ms. Fought distinguishes *Holsey* on the grounds that she promptly notified UNUM that her disability was the result of a staph infection and her doctors submitted statements corroborating her theory that it was not a pre-existing condition. These differences do not suggest a different result-neither prompt notification nor the doctors' general statements address the pre-existing condition language of the policy.

reactions to drugs taken in treatment of a pre-existing condition; the entire range of complications that may arise from surgical procedures (blood clots, strokes, nerve damage, infections, etc.); acts of medical malpractice and the like." Doc. 37 at 16. Focusing on the facts in this case, however, leads to the conclusion that UNUM's denial is reasonable because the complication of dehiscence of the sternal wound was foreseeable at the time of the cardiac surgery. Indeed, she had a "several day prolonged hospital stay" after the cardiac surgery "because of concerns over her sternal wound, given her marked obesity." UFOU-275. Ms. Fought's providers were concerned about infection, UFOU-410, 413, and when the dehiscence occurred, Ms. Fought's doctors ordered treatment including antibiotics to prevent an infection from developing. UFOU-303. The record is replete with evidence of the linkage between the coronary artery disease, its treatment, and the anticipated complications arising from that treatment.

NOW, THEREFORE, IT IS ORDERED, ADJUDGED AND DECREED:

(1) that Plaintiff's May 10, 1992, letter request for oral argument is denied, and

(2) that Defendant's Motion for Summary Judgment filed March 10, 2002 (Doc. 33) is granted.

DATED this 31st day of May 2002, at Santa Fe, New Mexico.

/s/ Paul Kelly, Jr.
United States Circuit Judge
Sitting by Designation

Counsel:

Robert P. Warburton and Ray M. Vargas, II, Sheehan, Sheehan & Stelzner, P.A., Albuquerque, New Mexico, for Plaintiff.

Kathryn D. Lucero and Kerri L. Peck, Foster, Johnson, McDonald, Lucero, Koinis, Albuquerque, New Mexico, for Defendant.

APPENDIX G

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

[Filed Dec. 3, 2001]

Civil No. 01-0124 PK/LFG (ACE)

SHIRLEY O. FOUGHT,

Plaintiff,

vs.

UNUM LIFE INSURANCE COMPANY OF AMERICA,

Defendant.

DEFENDANT'S RESPONSE OPPOSING PLAINTIFF'S MOTION FOR LEAVE TO CONDUCT DISCOVERY

This lawsuit arises out of Defendant UNUM Life Insurance Company of America's ("Defendant" or "UNUM") denial of disability benefits to Plaintiff Shirley Fought under a disability policy issued to Plaintiff's former employer by UNUM ("the Policy"). The Policy is an employee welfare benefit plan governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq*. Count I of Plaintiff's Complaint asserts a claim for benefits under 29 U.S.C. § 1132 (a)(1)(B). In the present motion, Plaintiff seeks leave to conduct discovery related to Defendant's alleged conflict of interest as plan administrator. Plaintiff's Motion [Doc. No. 27] p. 1. The discovery Plaintiff proposes to conduct includes requests for admission, interrogatories, and depositions. *Id*., p. 5. Because discovery is significantly limited in ERISA cases and Plaintiff has failed to articulate any extraordinary circumstances justifying a deviation from

the general rule against discovery, her Motion for Leave to Conduct Discovery should be denied.

* * *

While UNUM concedes that an inherent conflict of interest existed based solely on its status as both the insurer and the administrator of the plan, it emphatically denies that any such conflict influenced its decision to deny Plaintiff's claim for benefits. Indeed, other than relying on UNUM's status as both administrator and payor, Plaintiff offers no other explanation or support for why she believes that the inherent conflict of interest on UNUM's part affected its decision to deny Plaintiff benefits in this case. Such is not enough to justify discovery in this case.

* * *

APPENDIX H

29 U.S.C. § 1104(a)(1) (2000)

(a) Prudent man standard of care

(l) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter III of this chapter.

. . .

APPENDIX I

29 U.S.C. § 1132(a)(1) (2000)

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

. . .

Supreme Court, U.S.
FILED
MAR 30 2005
CLERK

No. 04-1000

IN THE

Supreme Court of the United States

UNUM LIFE INSURANCE COMPANY OF AMERICA,

Petitioner,

v.

SHIRLEY O. FOUGHT,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether an ERISA fiduciary with conflicting interests from those of its insured has the burden of proving that its interpretation of the terms of a benefit plan is reasonable and is supported by substantial evidence when reviewed under the traditional arbitrary and capricious standard of review.

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STATEMENT OF THE CASE

Respondent Shirley Fought adopts and incorporates by reference the statement of undisputed facts in the Tenth Circuit's substituted panel decision of August 13, 2004. App. at 2a-6a. Furthermore, Petitioner UNUM Life Insurance Company of America's ("UNUM") statement of the case is misleading when it suggests that Ms. Fought's initial submissions to UNUM on her disability claim were based on her pre-existing coronary artery disease.

Both before it denied Ms. Fought's claim for disability benefits and throughout the appeal process documented in the administrative record, UNUM knew, and did not dispute, that Ms. Fought was disabled and that the staph infection was the reason for her disability. C.A. Aplt. App. at 39, 158, 165. UNUM also acknowledged that the staph infection was not a "pre-existing condition." C.A. Aplt. App. at 158. Nevertheless, UNUM denied Ms. Fought's claim because it insisted that the staph infection related to elective coronary bypass surgery performed in treatment of her pre-existing coronary artery disease. C.A. Aplt. App. at 165.

Proceedings Below.

Ms. Fought brought this action against UNUM pursuant to the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(1)(B), to recover disability benefits under a disability insurance policy that UNUM issued to Ms. Fought's employer. UNUM was both plan administrator and the payer of benefits under the insurance policy.

UNUM initially denied that it had a conflict of interest, so Ms. Fought moved to conduct discovery into the nature and extent of UNUM's conflict. UNUM then changed tactics by admitting that it had an inherent conflict of interest. On that basis, UNUM successfully resisted Ms. Fought's discovery motion by arguing that in light of UNUM's admission, discovery into the nature and extent of its conflict was unnecessary.

UNUM moved for summary judgment. In response, Ms. Fought argued, *inter alia*, that in light of UNUM's serious conflict of interest, the district court should significantly reduce deference to UNUM's benefit denial decision under the arbitrary and capricious standard of review.[1] UNUM argued that Ms. Fought had not produced any evidence that UNUM's employees had financial incentives to deny claims or undue pressure from supervisors to deny benefits. In the absence of such evidence, UNUM contended that the sliding scale should not be weighted heavily against it, even though UNUM had opposed Ms. Fought's request to conduct discovery into these very issues on the ground that it was unnecessary where UNUM admitted an inherent conflict.

In granting UNUM's motion for summary judgment, the district court purported to take UNUM's conflict of interest

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[1] When a plan fiduciary has a conflict of interest, the Tenth Circuit, along with the majority of the circuit courts, has adopted a "sliding scale" approach, reducing deference in proportion to the severity of the conflict. *See Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 826-27 (10th Cir. 1996). The *Chambers* Court viewed the "sliding scale" approach as most consistent with the holding in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), that when a plan administrator or fiduciary is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion.

into account and purported to apply the "sliding scale" to UNUM's denial of benefits. In reality, the district court applied a fully deferential arbitrary and capricious standard of review. The district court specifically relied on language from *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1098 (10th Cir. 1999), where the court had determined that there was insufficient evidence of a conflict and that full deference was due to the plan administrator's decision.

Ms. Fought appealed. The Tenth Circuit issued its first decision on February 6, 2004, reversing the judgment of the district court. UNUM petitioned for rehearing and the panel issued a second slightly modified decision on August 13, 2004, again reversing the district court judgment on the same grounds as in the first decision. UNUM petitioned for rehearing *en banc*, which the *en banc* court denied on October 26, 2004.

In its ultimate decision, the panel reasoned that where the plan administrator operates under a conflict of interest but the evidence shows that the decision maker is insulated to some extent from the deleterious effects of the conflict, the court should consider the conflict as a factor, weigh the conflict evidence, and reduce deference accordingly. However, where the plan administrator is an insurer with an inherent conflict of interest, or the evidence shows that the decision maker is not insulated from the effects of the conflict and/or has incentive to deny claims, then the burden shifts to the plan administrator to prove that his or her interpretation of the terms of the plan is reasonable and that the application of those terms to the claimant is supported by substantial evidence. App. 14a-15a.

Most importantly, however, the Tenth Circuit thoroughly examined the entire administrative record for Ms. Fought's claim and concluded that UNUM's interpretation of the "pre-existing condition" exclusion was unreasonable and that UNUM's application of that exclusion to Ms. Fought's claim was not supported by substantial evidence. The panel did not consider these issues to be close calls. With respect to UNUM's interpretation of the pre-existing condition exclusion, the court noted:

> UNUM seems to suggest that it need not cover anything for which it can construct a but/for story. If we were to accept this contention, we would effectively render meaningless the notion of the pre-existing clause by distending the breadth of the exclusion.

App. 22a. Likewise, when disposing of UNUM's argument that there was "conflicting evidence in the record" as to the cause of Ms. Fought's disability, the court said:

> Moreover, the only arguably conflicting evidence here is the note from Dr. Dubroff that states both that Ms. Fought may be disabled "due to her heart condition" and that her "staph infection was not a pre-existing condition. Aplt.App. at 154. The bulk of Ms. Fought's medical records indicate that she was recovering well from the surgery; the onset of the staph infection, which originated from an unknown origin, was the debilitating condition. UNUM is unable to offer "more than a scintilla" of evidence [citation omitted], that the staph infection was a manifestation of the pre-existing coronary artery disease, that it was caused by the

> pre-existing condition, or that it was substantially contributed to by or resulted from the pre-existing condition.

App. 31a. It is on this latter basis that the panel held "that the plan's language here does not reasonably apply to the attenuated chain of events between Ms. Fought's pre-existing coronary artery disease and her disabling staph infection and that UNUM's denial of benefits was not supported by substantial evidence." App. 32a.

REASONS FOR DENYING THE PETITION

UNUM's petition seeks to create a tempest, but it is a tempest in a teapot "unworthy of the solemn adjudication attempted for it."[2] UNUM's petition quotes selective portions of the Tenth Circuit's opinion and strings them together in a way which suggests a significant "conflict" among the circuits, when in fact the circuit differences are merely minor variations on the theme announced by this Court in *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115 (1989), that reviewing courts must weigh a plan administrator's conflict of interest as a "factor" in determining whether an abuse of discretion has occurred. Given that reality, Unum's petition should be denied for three reasons.

First, there has been a significant change in the Department of Labor regulations governing claims procedures under ERISA that parallels and reinforces what the Tenth Circuit did here. The new rule applies to all claims filed under plans providing disability benefits on or after

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[2] The United States Magazine and Democratic Review, Vol. I, p. 171 (Washington, D.C. 1838).

January 1, 2002. *See* 29 C.F.R. § 2560.503-1(o). It makes no sense for the Court to spend its valuable time reviewing a decision whose primary application and impact is limited to an ever shrinking number of pre-2002 claims.

Second, the court's holding below was based on the specific facts presented by the administrative record in Ms. Fought's claim and was correctly decided on those facts. It is well settled that the Court reviews judgments, not opinions. *See Texas v. Hopwood*, 518 U.S. 1033 (1996). A fair reading of the Tenth Circuit's decision demonstrates that the court merely applied "plain language" principles to properly interpret the "pre-existing condition" exclusion in UNUM's insurance policy; that UNUM's interpretation of that clause was a grossly attenuated "but for" approach that would "effectively render meaningless the notion of the pre-existing conditions clause," App. 22a; and that the administrative record did not contain more than a "scintilla" of evidence that Ms. Fought's disability was caused by her pre-existing coronary artery disease. App. 31a. On this record, UNUM's decision would not have passed muster in any circuit, regardless of the variations in their approach to conflicted plan fiduciaries.

Third, UNUM's "presumption of actual conflict" argument is a straw man which it uses to exaggerate the minor differences between the circuit courts. UNUM alleges that the Tenth Circuit has imposed an irrebuttable presumption of an "actual" conflict and has thereby created a presumption of bias or partiality which the insurer must then rebut. Petition at 19-20. Having already admitted below that it had an inherent conflict of interest, UNUM engages in semantical hair-splitting in an attempt to draw distinctions between "apparent," "inherent," and "actual" conflicts of interest

where no distinction exists. UNUM then tries to blur the distinction between the existence of a conflict of interest and the ultimate consideration of whether the conflict of interest tainted the ERISA fiduciary's adverse benefit determination.

Here, the Tenth Circuit did not have to presume a conflict of interest on UNUM's part because UNUM plainly admitted that it had an inherent conflict of interest. Likewise, the Tenth Circuit did not presume that UNUM's denial of Ms. Fought's claim was tainted by conflict. Instead, the panel carefully considered: (1) whether UNUM's interpretation of the pre-existing condition exclusion was reasonable and concluded that it was not; and (2) whether the application of that exclusion to Ms. Fought's disability was supported by substantial evidence in the administrative record and concluded that it was not.

I. A SIGNIFICANT CHANGE IN DEPARTMENT OF LABOR REGULATIONS GOVERNING ERISA CLAIMS PROCEDURES PARALLELS AND REINFORCES THE TENTH CIRCUIT'S DECISION BELOW, MAKING REVIEW OF THIS CASE UNNECESSARY.

On September 9, 1998, the United States Department of Labor ("DOL") proposed a sweeping overhaul of the rule governing claims procedures of employee benefit plans covered by ERISA. *See* 63 Fed. Reg. 48,390 (1998) (codified at 29 C.F.R. § 2560.503-1). DOL proposed new standards "intended to ensure more timely benefit determinations, improved access to information on which a benefit determination is made, and greater assurance that participants and beneficiaries will be afforded a full and fair review of

denied claims." *Id.* The final rule applies to disability claims submitted on or after January 1, 2002 (hereinafter the "Rule").[3]

If Ms. Fought's claim for disability benefits had been subject to the Rule, the Tenth Circuit would have reached the same result, but the panel's reduction of deference analysis would be largely irrelevant. Instead of focusing on whether the plan administrator labors under a conflict of interest, the Rule effectively prohibits the questionable claims practices that UNUM used to deprive Ms. Fought of a full and fair review, and would have automatically entitled Ms. Fought to trial *de novo* in the district court, with no deference afforded to UNUM's adverse benefit decision.

For example, UNUM argued below that one of Ms. Fought's treating physicians had submitted a statement that, while confirming that her staph infection was not a pre-existing condition, also suggested that Ms. Fought's disability may be due to her heart condition. App.31a. While noting that the overwhelming weight of the evidence pointed to the staph infection as the disabling condition, the Tenth Circuit also criticized UNUM for failing to obtain an independent medical evaluation if it questioned the cause of Ms. Fought's disability. *Id.*

The Rule established the following minimum standards when, as here, a claim decision is based in whole or in part on a medical judgment:

> (iii) Provide that, in deciding any appeal of any adverse benefit determination that is based in

[3] A final rule was initially published on November 21, 2000 at 65 Fed. Reg. 70,246 (2000), but was subsequently amended to modify the effective date of the rule only as it applied to health benefit plans, and was re-published on July 9, 2001 at 66 Fed. Reg. 35,889 (2001).

> whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
>
> (iv) Provide for the identification of medical or vocational experts whose advice whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

29 C.F.R. § 2560.503-1(h) (iii)-(iv).

The Rule also spells out the consequences for failure to strictly comply with the minimum standards for full and fair claim reviews.

> (*l*) *Failure to establish and follow reasonable claims procedures.* In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

29 C.F.R. § 2560.503-1(l). During the rule-making process, employers and insurers lobbied DOL to keep sub-paragraph (l) out of the final rule. In rejecting the insurance industry arguments, DOL clearly expressed its view as follows:

> In the view of the Department, the standards in the regulation represent essential aspects of the process to which a claimant should be entitled under section 503 of the Act. A plan's failure to provide procedures consistent with these standards would effectively deny a claimant access to the administrative review process mandated by the act. Claimants should not be required to continue to pursue claims through an administrative process that does not comply with the law. **At a minimum, claimants denied access to the statutory administrative review process should be entitled to take that claim to court under section 502(a) of the Act for a full and fair hearing on the merits of the claim.**

65 Fed. Reg. 70,256 (2000) (emphasis added). In an earlier statement addressed to the same provision, DOL also said,

> It is the Department's view that, in such a case, any decision that may have been made by the plan with respect to the claim is not entitled to the deference that would be accorded to a decision based upon a full and fair review that comports with the requirements of section 503 of the Act.

63 Fed. Reg. 48,397 (1998).

While the Rule admittedly is not directly on point as to the question presented by Ms. Fought's case, given its close relation to the factual issues that influenced the panel decision below, the Rule will doubtless have a broad influence on the circuit courts in how they address the conflicted fiduciary/ standard of review issue. At the very least, it must be conceded that the new DOL Rule requiring independent administrative review of medical decisions, and *de novo* district court review if such independent administrative review does not occur, provides an entirely different legal backdrop for deciding the question presented here. Thus, the conclusions reached by the circuit courts on the conflict of interest issue under the prior regulatory regime provide little or no insight on how the issue will play out under the new one.

UNUM's complaint that the Tenth Circuit's approach below is "rigid" and unfairly shifts the burden of proof to conflicted fiduciaries rings hollow when compared to the trial *de novo* remedy afforded claimants under the new Rule when the fiduciary does not strictly comply with the minimum standards for full and fair review. Since the new Rule applies uniformly to all plan administrators, not just those laboring under conflicts of interest, UNUM has no credible complaint of disparate treatment by the Tenth Circuit here.

In summary, the significant change in the DOL Rule governing ERISA claims procedures effectively limits the precedential value of the Tenth Circuit's decision here, as well as the decisions of other circuit courts addressed to the same issue, to a relatively insignificant and shrinking number of pre-January 1, 2002 benefit denials. For post-January 1, 2002 benefit denials, the reviewing courts will necessarily focus on whether the plan fiduciary strictly complied with

the minimum standards for providing a full and fair review, and will be less concerned with whether a plan fiduciary labored under a conflict of interest. Accordingly, it makes no sense for this Court to spend its valuable time attempting to resolve minor differences among the circuits, the importance of which have now been vastly diminished by the amendments to 29 C.F.R. § 2562.503-1.

II. THE TENTH CIRCUIT'S DECISION WAS BASED ON THE SPECIFIC FACTS IN THE ADMINISTRATIVE RECORD AND WAS CORRECTLY DECIDED BASED UPON THOSE FACTS.

UNUM devotes a scant seven paragraphs in its petition to the factual background of Ms. Fought's claim. Under UNUM's rendition, Ms. Fought's initial application for disability benefits attributed her disability to her pre-existing coronary artery disease, and only after UNUM denied Ms. Fought's claim did she suddenly raise the staph infection as the real cause of her disability. UNUM contends that it upheld its claim denial because "under its reading of the pre-existing condition exclusion, it perceived the staph infection as sufficiently related to the heart surgery to fall under that provision." Petition at 5.[4]

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[4] UNUM fails to mention that the initial application for disability benefits was submitted on June 15, 1999 by well-meaning individuals at Fought's place of work who had incomplete knowledge of Fought's medical condition at the time. On June 15, 1999, Ms. Fought was hospitalized, in extreme pain, heavily sedated and was lapsing in and out of consciousness as her body battled the effects of the staph infection.

However, the Tenth Circuit undertook a decidedly fuller and fairer review of the administrative record than did UNUM in reaching its decision. The panel concluded as follows:

> The bulk of Ms. Fought's medical records indicate she was recovering well from the surgery; the onset of the staph infection, which originated from an unknown origin, was the debilitating condition. UNUM is unable to offer "more than a scintilla of evidence" [citation omitted] that the staph infection was a manifestation of the pre-existing coronary artery condition, that it was caused by the pre-existing condition, or that it was substantially contributed to by or resulted from the pre-existing condition.

App. 31a. The panel further concluded that under UNUM's reading of the pre-existing condition exclusion, UNUM believed "it need not cover anything for which it can construct a but/for story" and that "the chain of non-proximate causation that UNUM asserts in [Ms. Fought's] case is attenuated to the point of absurdity." The court further explained:

> [UNUM's] argument necessarily goes something like this: but for the pre-existing coronary artery disease, Ms. Fought probably would not have had the surgery; but for the surgery, Ms. Fought would not have had a surgical wound; but for the surgical wound, Ms. Fought's previously undetected osteoporotic sternum would not have prevented her doctors from closing her wound in a more conventional manner, which might have given the wound greater stability and resistance to the lateral

> tension on the wound exerted by Ms. Fought's large breasts; but for the combination of the surgical wound, Ms. Fought's osteoporotic sternum and her large breasts, the wound probably would not have dehisced, thereby providing an entry point for the staph infection several weeks after the surgery; but for the fact that the staph infection was resistant to antibiotics, entered Ms. Fought's bloodstream, and eventually spread to other parts of her body, Ms. Fought would not be disabled.

App. 21a-22a.

Not only was UNUM's interpretation of the pre-existing condition exclusion objectively unreasonable, the panel also pointed out that UNUM's interpretation was undermined by DOL regulations, which require a substantial connection between a pre-existing condition and a resulting disability to trigger a pre-existing condition exclusion. App. 22a-23a. The panel also considered that UNUM's expansive interpretation of its pre-existing condition exclusion was not supported by any of the cases relied upon by UNUM and the district court and that the case most directly on point, *Vander Pas v. UNUM Life Insurance Company of America*, 7 F. Supp.2d 1001 (E.D. Wisc. 1998), ruled against UNUM on an even less attenuated set of facts. Finally, the panel noted that if UNUM had intended to exclude coverage for disabilities arising from medical or surgical treatment of a pre-existing condition, it had the opportunity to expressly add those words to the exclusion and did not do so. The panel concluded that is was unreasonable to allow UNUM to do so *post facto* to the detriment of Ms. Fought and other insureds. App. 28a.

The Supreme Court reviews judgments, not opinions. *See Texas v. Hopwood*, 518 U.S. 1033 (1996). Moreover, it is a well-settled rule that if the decision below is correct on any ground, it must be affirmed. *See, e.g., Helvering v. Gowran*, 302 U.S. 238, 245 (1937). Here, UNUM admitted an inherent conflict of interest, and the Tenth Circuit determined that in light of the admitted conflict, a reduction in deference was appropriate in reviewing UNUM's denial of benefits. However, regardless of whether the Tenth Circuit reduced deference more than might have occurred in another circuit, under the facts of Ms. Fought's case, UNUM's benefit denial was arbitrary and capricious in *any* circuit even under the most deferential standard of review employed in conflict-of-interest cases.

III. UNUM's CLAIM THAT THE TENTH CIRCUIT HAS ESTABLISHED A "PRESUMPTION OF CONFLICT" IS OVERBLOWN AND UNWORTHY OF CERTIORARI.

UNUM complains that the decision below equates an apparent or inherent conflict with an actual conflict and creates a "presumption of wrongdoing that the fiduciary must rebut." Petition at 19. UNUM engages in semantical hairsplitting in an effort to draw distinctions where none exist. Black's Law Dictionary defines "apparent" as follows:

> That which is obvious, evident, or manifest; what appears or has been made manifest. That which appears to the eye or mind; open to view; plain;

> patent. In respect to the facts involved in an appeal or writ of error, that which is stated in the record.[5]

Webster's Dictionary defines "inherent" as, "Existing as an essential constituent or characteristic: INTRINSIC."[6] It is undisputed that UNUM admitted to having an inherent conflict of interest. *See* C.A. Aplt.App at 12, 25. In its petition UNUM claims that the Tenth Circuit misunderstood its concession that, in fact, UNUM was only admitting an "*apparent* conflict" as opposed to an actual conflict. Petition at 8. Based on the foregoing definitions, this is a distinction without a difference.

If what UNUM really means to argue is that its denial of benefits was not tainted by its inherent conflict of interest, that is, of course, a factual issue that the Tenth Circuit has already resolved. The court of appeals recognized that the best evidence on that issue was whether UNUM's interpretation of its "pre-existing condition" exclusion was reasonable and whether its application of that exclusion to Ms. Fought was supported by substantial evidence in the administrative record. As previously noted, the panel examined the entire administrative record and concluded as a matter of law that UNUM's interpretation was unreasonable and its benefit denial was not supported by substantial evidence.

Furthermore, UNUM's repeated assertions that the Tenth Circuit has created a "presumption of wrongdoing" or a "presumption of actual partiality" are not supported in that

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[5] BLACK'S LAW DICTIONARY 88 (5th ed. 1979).

[6] WEBSTER'S II NEW RIVERSIDE UNIVERSITY DICTIONARY 629 (1988).

court's opinion. The word "presumption" does not even appear in the Tenth Circuit's opinion. UNUM apparently believes that because the court of appeals required it to prove that its interpretation of the plan was reasonable and that its benefit denial was supported by substantial evidence in the administrative record, the court of appeals was establishing a presumption of wrongdoing. However, the threshold showing of reasonableness and substantial evidence has, for decades, been the bedrock for sustaining a plan administrator's decision under the traditional arbitrary and capricious standard of review. The court of appeals simply puts insurers on notice that decisions based on strained and questionable interpretations of the plan and selective or self-serving consideration of the evidence will not be sustained.

In summary, UNUM's petition goes to great lengths to portray the Tenth Circuit's decision as extreme and at odds with this Court's guidance in *Firestone*. However, a fair reading of the decision below demonstrates that UNUM's arguments are not well taken. Petitioner's position is inconsistent with the existing ERISA regulations on the subject. The TenthCircuit's judgment in this case was based on UNUM's grossly attenuated "but for" analysis of the pre-existing condition clause in the contract of insurance, which was arbitrary under any standard of review. And, in any event, the Tenth Circuit's approach is in harmony with *Firestone* and in accord with a solid majority of circuit courts, which have adopted the "sliding scale" approach to reducing deference in the case of conflicted ERISA fiduciaries.

CONCLUSION

For the foregoing reasons, Respondent urges that the Petition for a Writ of Certiorari be denied.

Respectfully submitted,

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No. 04-1000

Supreme Court, U.S.
FILED
APR 13 2005
OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,

v.

SHIRLEY O. FOUGHT,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

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PETITIONER'S REPLY BRIEF

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UNUM LIFE INSURANCE COMPANY OF AMERICA,
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Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

PETITIONER'S REPLY BRIEF

I. THE DEPARTMENT OF LABOR REGULATIONS ARE IRRELEVANT TO THE STANDARD OF REVIEW ISSUE.

Ms. Fought concedes that the DOL regulations on which she primarily relies "admittedly [are] not directly on point as to the question presented by Ms. Fought's case." Opposition at 11. That is an understatement. The DOL regulations do not remotely address the standard of review applied by federal courts in reviewing ERISA benefits determinations, and the fact that those regulations have been amended since UNUM decided the benefit claim in this case certainly does not moot the issue presented in the petition.

The DOL regulations set forth the minimum requirements for *internal plan review* of group health and disability claims

under Section 503 of ERISA, 29 U.S.C. § 1133(2) (2000). They require every plan to "establish and maintain reasonable procedures governing . . . claims procedures," which are defined as "the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations." 29 C.F.R. § 2560.503-1(b) (2004). The "appeal[s] of adverse benefit determinations" that the DOL regulations address are limited to "appeal[s] [from] an adverse benefit determination to an appropriate named fiduciary of the plan," *id.* § 2560.503-1(h)(1), in other words, to what are generally referred to as "administrative appeals."

The issue in this case has nothing to do with a plan's internal review process, but relates solely to the standard of review in *judicial appeal actions* under Section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B) (2000). In particular, UNUM seeks resolution of the conflicting approaches that the circuits employ to resolve the following questions: (a) Under what circumstances an insurance company's dual role as funding source and ERISA claim fiduciary presents a conflict of interest; and (b) how such a conflict, if established, impacts the arbitrary and capricious judicial review standard in Section 502(a)(1)(B) actions. The DOL regulations do not purport to reach these subjects and they set forth no requirements whatsoever related to the standard of review in judicial review actions filed under Section 502(a)(1)(B).

Ms. Fought relies on the provision that, if a plan fails to follow the claims procedures set forth in the DOL regulations, the "claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act . . ." 29 C.F.R. § 2560.503-1(*l*) (2004), *quoted in* Opposition at 9-10. But that section says nothing about the standard of review applicable in a subsequent judicial review

action; it merely states when such an action is available to a disappointed claimant.[1]

UNUM's internal review of Ms. Fought's claim would not have violated the 2000 amendments to the DOL regulations even if they had been in place when UNUM considered the claim in 1998 and 1999. The DOL regulations provide that "in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment," the fiduciary must "consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment." 29 C.F.R. § 2560.503-1(h)(3)(iii) (2004), *incorporated in* 29 C.F.R. § 2560.503-1(h)(4) (2004). In this case, the medical facts were undisputed and the denial of benefits was not "based in whole or in part on a medical judgment," but on the meaning of the policy's pre-existing condition provision. *See* Petition at 7-8 n.1. Thus, the DOL regulations would not have required UNUM to consult with a medical professional. But even if medical consultation had been required, UNUM's medical department reviewed Ms. Fought's claim during the administrative appeal process. *See* App. 4a-5a & n.1.

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[1] When the DOL initially published the proposed rules in 1998, the agency stated its view that, if a plan failed to follow the proposed administrative claim procedures, a benefits denial would not be "entitled to . . . deference" in a subsequent judicial appeal. 62 Fed. Reg. 48390, 48397 (Sept. 9, 1998). However, that thought did not survive the following two years of extensive consideration of and revision to the proposed regulations, and was not carried over into the final rules. Thus, Ms. Fought is wrong in stating that "the new DOL Rule requir[es] . . . *de novo* district court review" if the administrative procedures are not fully satisfied. Opposition at 11; *see also id.* (describing regulations as providing "trial *de novo* remedy . . . when the fiduciary does not strictly comply with the minimum standards for full and fair review"). In any event, as explained in the text, there is no basis for Ms. Fought's premise that UNUM's administrative review in this case would have violated the DOL regulations.

The Tenth Circuit's standard of review analysis did not turn on whether Ms. Fought's claim presented a question of medical judgment, whether UNUM obtained appropriate medical consultation, or whether UNUM otherwise complied with either the old or new DOL regulations.[2] It turned only on UNUM's status as an insurance company that both serves as a claim fiduciary and funds the plan through an insurance policy. The DOL regulations have no bearing on the issue that the Tenth Circuit decided, that the circuits have clashed on, and that this Court should resolve.

II. THERE ARE IRREFUTABLE CONFLICTS AMONG THE CIRCUITS ON THE STANDARD OF REVIEW ISSUE.

The principal bases for granting the petition are (a) the massive conflicts among the circuits on the appropriate standard of review in dual-role cases, and (b) the conflict between the Tenth Circuit's analysis of that issue and this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). Petition at 10-20. Incredibly, Ms. Fought does not respond to either of these arguments other than in the most conclusory fashion. *See* Opposition at 5, 17. She does not address the substance of the standard of review analysis in *Firestone*, nor even mention—much less try to reconcile—any of the two-dozen court of appeals decisions or multiple law review articles cited in the petition, which evidence the overwhelming conflicts in the lower courts.

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[2] In dictum, the Tenth Circuit stated that UNUM's failure to obtain an IME was a procedural irregularity evidencing a conflict of interest that would have independently justified shifting the burden to UNUM to defend its denial of benefits. App. 16a, 31a-32a. However, the DOL regulations do not oblige a fiduciary to obtain an IME where an internal medical review, as occurred in this case, satisfies the medical consultation requirement. Furthermore, whether such a conflict should cause the burden of proof to shift to the insurer is an integral part of the issue presented in the petition.

Ms. Fought's silence is telling. She says nothing because there is nothing she can say. The split in the circuits is undeniable and not reconcilable, as most recently confirmed by the First Circuit. In *Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan*, ___ F.3d ___, No. 04-1986, 2005 WL 678952 (1st Cir. Mar. 25, 2005), the court adhered to First Circuit precedent holding that an insurer's "dual status as payor of benefits and administrator with respect to the LTD benefits" "was not alone sufficient to alter the [deferential] standard of review." 2005 WL 678952, at *5. The court observed, however, "that other circuits have rejected the market forces rationale and specifically recognized a conflict of interest when the insurer of an ERISA plan also serves as plan administrator, *although there is no consistent approach in adjusting the standard of review*." *Id.* at *6 n.5 (citing *Fought* and other cases) (emphasis added).

The issue presented in this case—the existence and impact of a "conflict" under *Firestone*—has percolated for over fifteen years in the lower courts. The law below is confused, confusing, and inconsistent. The conflicts in the law are real and pressing and merit resolution by this Court.

III. THIS CASE IS IDEALLY SUITED FOR THE COURT TO RESOLVE THE CONFLICTS AMONG THE CIRCUITS.

Unable to rebut the existence of a conflict in the lower courts, Ms. Fought argues instead that this is not the right case for resolution of the circuit split. Implicitly conceding the division among the circuits on the law, she claims that on the record in this case, UNUM's denial of benefits "would not have passed muster in any circuit, regardless of the variations in their approach to conflicted plan fiduciaries." Opposition at 6. UNUM, obviously, disagrees. The district court (a Tenth Circuit active judge sitting by designation),

which applied the Tenth Circuit's pre-*Fought* sliding scale approach and upheld the benefits denial as neither arbitrary nor capricious, also disagreed. *See* App. 6a-7a.

But Ms. Fought's argument is beside the point. UNUM's petition presents a legal issue: What is the appropriate standard of review of an ERISA fiduciary's denial of benefits when the plan vests the fiduciary with discretion, and the fiduciary is an insurance company that also funds the plan through an insurance policy? The only factual predicates for resolving that issue are (a) whether the plan gives the fiduciary discretion, (b) whether the fiduciary is an insurance company, and (c) whether the insurance company also funds the plan. Those facts are undisputed in this case and those are the only facts that the Tenth Circuit found relevant in its blanket indictment of all dual-status insurers as presumptively conflicted. *See* App. 8a-17a (discussing and determining standard of review without reference to any of the facts argued by Ms. Fought); *id.* at 7a-8a (confirming that court did not consider the facts argued by Ms. Fought until *after* it had adopted a reduced deference standard).

The question is one of law, the parties developed an adequate record on UNUM's motion for summary judgment, and the Tenth Circuit treated the question at length in a detailed opinion. The issue is now ready for determination by this Court.

CONCLUSION

For the reasons set forth in the petition and in this reply brief, the Court should grant the petition to reconcile the intercircuit conflicts on the important issue presented by this case.

Respectfully submitted,

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MOTION FILED
MAR 3 0 2005

(3)

No. 04-1000

IN THE
Supreme Court of the United States

UNUM LIFE INSURANCE COMPANY OF AMERICA,

Petitioner,

v.

SHIRLEY O. FOUGHT,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

MOTION OF AMERICA'S HEALTH INSURANCE PLANS AND THE AMERICAN COUNCIL OF LIFE INSURERS FOR LEAVE TO FILE A BRIEF AS *AMICI CURIAE* IN SUPPORT OF PETITIONER AND BRIEF *AMICI CURIAE*

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America's Health Insurance Plans ("AHIP") and the American Council of Life Insurers ("ACLI") ("amici") hereby move, pursuant to S. Ct. R. 37.2, for leave to file a brief *amici curiae* in support of the petition for writ of *certiorari* to the Supreme Court of the United States. *Amici* are filing this motion because Respondent has declined to consent to this *amici curiae* brief.[1] A copy of the proposed brief is attached.

As more fully explained at pages 1-3 of the brief under "Interest of *Amici Curiae*," *amici* are trade associations representing members who insure and administer ERISA disability and other benefit plans. They and their membership will suffer the effects of the Tenth Circuit's decision in *Fought v. UNUM Life Insurance Co.*, 379 F.3d 997 (10th Cir. 2004), creating an automatic and irrebuttable presumption of impermissible bias with respect to any benefits decisions made by insurers and other payors of ERISA benefits.

This brief will assist the Court in determining whether to grant *certiorari* because *amici* are uniquely positioned to point out: (1) the importance of this case to all insurers and payors of ERISA plan benefits, including self-funded payors ("Payor Fiduciaries"), not only in the Tenth Circuit, but throughout the United States; (2) the need for this Court to grant *certiorari* in this case in view of the various Circuits' inability to identify and comply with the appropriate standard of deference that should be granted to benefits decisions made by Payor Fiduciaries; (3) the role Payor Fiduciaries play in helping plans administer benefits; (4) Congress' intent in establishing ERISA as a uniform policy for provision of disability benefits; and, most importantly, (5) the harmful impact the Tenth Circuit's decision in *Fought* will have on this nation's voluntary employer-based health care and other benefits systems.

---

[1] Upon being contacted by counsel for *amici* on March 29, 2005, counsel for respondent denied his consent for *amici* to file this brief. The letter of consent from the petitioner is being submitted herewith.

Accordingly, *amici* respectfully request that the Court grant leave to file the attached brief *amici curiae*.

Respectfully submitted,

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INTRODUCTION

INTEREST OF *AMICI CURIAE*

America's Health Insurance Plans ("AHIP") and the American Council of Life Insurers ("ACLI")[1] respectfully submit this brief urging the Court to grant the Petition for a Writ of Certiorari (petition) in this case. Amici support the petition because the application of a proper judicial review standard to benefit coverage decisions made by ERISA fiduciaries who are insurers ("Payor Fiduciaries") is essential to the survival of this nation's voluntary employer-based health care and disability benefits system. The radical review standard devised by the United States Court of Appeals for the Tenth Circuit, that such fiduciaries' judgments respecting the proper interpretation of the Employee Retirement Income Security Act of 1974 ("ERISA") plans' documents are not entitled to either recognition or deference solely because of the purported influence of an economic stake in such decisions, presents a serious threat to the continued viability of that system. 29 U.S.C. § 1001, et seq. (2005); *Fought v. UNUM Life Ins. Co.*, 379 F.3d 997 (10th Cir. 2004)("*Fought*").

AHIP's membership consists of approximately One Thousand Three Hundred (1,300) companies who administer and/or insure benefits including disability, long-term care, supplemental coverage, health, and pharmaceutical coverage to more than 200 million Americans, the very great majority of whom are participants in, or beneficiaries of, employee benefit plans under ERISA. AHIP seeks to facilitate, preserve and increase the availability of affordable benefit coverage related to health care and to disability. AHIP has accumulated substantial knowledge and experience about the proper administration of ERISA plans and the responsibilities of ERISA fiduciaries

[1] Pursuant to Sup. Ct. R. 37.6, ACLI's and AHIP's counsel of record hereby certifies that this brief was authored in whole by Epstein Becker & Green, P.C., and that no individual or entity other than amici curiae AHIP and ACLI have contributed monetarily to the preparation or submission of this brief.

through its members' activities on behalf of employers and other ERISA benefit plan sponsors.

The American Council of Life Insurers ("ACLI") is the largest life insurance trade association in the United States, representing the interests of 354 member legal reserve life insurers operating in the United States. These 354 member companies account for 69 percent of life insurance premiums in the United States among legal reserve life insurance companies, 51 percent of disability income insurance premiums and 79 percent of annuity considerations. The life insurance policies issued by ACLI members include employer-sponsored group disability insurance policies and group life policies. The annuities issued include group annuities issued to employer-sponsored retirement plans. The vast majority of the products sold by ACLI members in the group employee benefits market are subject to the requirements of ERISA.

Of substantial concern to *amici* and their members is the ongoing conflict and confusion among the circuit courts of appeals regarding the standard of review applicable to actions under ERISA alleging wrongful denial of benefits when an insurer, or any other administrator or fiduciary, is operating under a conflict of interest. *Amici* are uniquely positioned to explain the practical effects of this ongoing conflict upon employer-sponsored benefit plans, and the need for the Court to resolve this conflict.

Amici firmly believe that the standard of judicial review enunciated by the Tenth Circuit in *Fought* will jeopardize the continued sponsorship of ERISA benefit plans by employers and, thus, produce a result directly contrary to that intended by Congress when it enacted ERISA. The Tenth Circuit's decision rests on the undocumented factual assumptions that Payor Fiduciaries, their officers, their employees and their agents are: (a) inherently biased; (b) unable to comply with ERISA's fiduciary standards; and (c) incapable of objective judgment in their interpretation of plan documents governing benefit

coverage criteria. Available data, however, establishes that disability payors approve the overwhelming majority of claims for coverage,[2] and have no hesitancy to overturn their own initial denials when they conclude that their judgment was unsound.[3]

Amici's interest is not limited to the impact of the Tenth Circuit's decision on disability insurers alone. The principal holding of the Tenth Circuit's decision, that payors of benefits are presumptively biased and incapable of reaching legitimate and reasonable interpretations of plan documents, is fully applicable to insurers of ***any*** type of benefit which is offered by ERISA plans. Indeed, the decisional principle announced in *Fought* that "payors" who serve as claim fiduciaries can never be assumed to be capable of objectivity is applicable to employers and trustees of self-funded ERISA benefit plans. Through this brief, AHIP and ACLI not only seek to protect the interest of their members, they seek to protect the interests of ***all*** Payor Fiduciaries.

REASONS WHY THE PETITION SHOULD BE GRANTED

The Petition should be granted because the Tenth Circuit's decision in *Fought* is inconsistent with fundamental purposes and principles of ERISA and the prior rulings of this Court. The ruling in *Fought*, if allowed to stand, threatens the viability of the privately funded, employer-based system of economic protection for: (a) millions of workers who suffer disabling injuries; and (b) millions of workers, retirees and their covered

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[2] For example, "Of the approximate 464,000 new disability claims filed with [UNUM] in 2003, approximately 90% were paid. Of the remainder, approximately one-half were no longer claiming benefits when payments would have begun. Slightly more than 1 percent were determined not to be disabled." UnumProvident Corp., *Our Customer Commitment at Claim Time, at http://www.unumprovident.com/aboutus/ourcompanies/more.aspx#protecting.*

[3] See discussion *infra* pp. 14-15.

dependents who obtain health care coverage through employment.[4] The Tenth Circuit's unprecedented ruling that Payor Fiduciaries vested with the discretion to interpret ERISA plan documents must be presumed to be biased and incapable of forming reasonable interpretations of such documents is directly contrary to this Court's clear ruling that the courts should grant deference to those interpretations. *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

The *Fought* decision signals that at least one lower court has failed to grasp the instruction of this Court in *Firestone*, or believes that it is free to reject that instruction. If the *Fought* decision is allowed to stand, other courts might reasonably conclude that the teaching of *Firestone* is less definitive and authoritative than the clear text of the Court's opinion. Those courts may very well conclude, as the Tenth Circuit has, that they are free to create their own approaches to the invalidation of plan fiduciaries' benefit coverage decisions, and substitute their own views of the benefits that ERISA plans should cover. That prospect is a substantial deterrent to the willingness of employers to provide ERISA plan benefits of any kind to their employees. Second only to excessive cost, the biggest deterrent to the sponsorship of benefit plans by employers is uncertainty and lack of uniformity with respect to the scope of the benefits they may be obligated to cover and administer.

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[4] The Bureau of Labor Statistics identifies the percentage of workers employed by private industry covered by long term disability ("LTD") benefit programs in 2003 at twenty eight percent (28%) of the workforce, and by short term disability ("STD") benefit programs at about approximately thirty-seven percent (37%). Bureau of Labor Statistics, U.S. Department of Labor, *National Compensation Survey: Employee Benefits in Private Industry in the United States, 2002-2003*, at 7 (Jan. 2005).

ARGUMENT[5]

I. THE VOLUNTARY, PRIVATE DISABILITY COVERAGE SYSTEM VITAL TO THE NATION'S WELL BEING IS JEOPARDIZED BY THE RULING IN THE *FOUGHT* CASE

In 1963, only 3 million people were covered by disability policies. By 1984 there were more than 22 million people with long term disability protection, with 17.3 million covered under group policies and 5.5 million with individual policies. Diane B. Hill, *Employer-Sponsored Long-Term Disability Insurance*, 110 Monthly Lab. Rev. 16 (July 1987), *available at* http://www.bls.gov/opub/mlr/1987/07/art2full.pdf. Currently there are over 33.8 million employees covered by disability policies. JHA, Inc., *The JHA Disability Fact Book*, at 1 (2003/2004 ed.). The number of persons with disability benefits has increased ten-fold since 1963, demonstrating the critical and growing importance of this benefit, and the necessity of avoiding the creation of arbitrary and unhelpful barriers that impair its availability to an aging worker population.

One reason for the increasing growth of and reliance on disability benefit plans is the substantial aging of the workforce caused by so-called "Baby Boomers" (individuals born between 1946 and 1964). This aging factor is important because older workers are five times more likely to submit a disability claim than their younger counterparts.[6] The data show that, for long term disability, workers in the fifty-two to fifty-seven year old

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[5] Amici support all of Petitioner's Arguments but specifically concur in the argument presented in Section IC, at pp. 16-18, of the Petition, respecting the inconsistent interpretation among the lower courts of this Court's decision in *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

[6] BenefitNews Connect, *Disability Claims Up As Older Workers Delay Retirement*, (May 15, 2003), *at* http://www.benefitnews.com/detail.cfm?id=4516&terms=|delay||up||older||retirement||workers||claims||disability|.

age cohort submit approximately eighteen claims per thousand, while workers in the twenty-two to twenty-seven year old age cohort only submit about three claims per thousand.[7] The former Health Insurance Association of America, which became a part of AHIP, reported that the Social Security Administration predicts a thirty-seven percent (37%) increase in instances of disability due to the aging workforce.[8]

According to a National Association of Insurance Commissioners ("NAIC") report, approximately 18 % of males and 22% of females, under the age of 45, are likely to become disabled for a period of at least 90 days during their working lives. NAIC, *Commissioner's Individual Disability Table A (1985), in* America's Health Insurance Plans, *Disability Insurance: A Missing Piece in the Financial Security Puzzle* 5 (Oct. 2004). Another study indicates that, before age thirty-five, a worker has a one-in-four chance of becoming disabled for more than ninety days during the rest of his or her working life.[9] Recent data also suggest that one third of all workers between twenty five and sixty will experience an injury or illness that will keep them out of work for three months or longer.[10] Nearly sixty percent of disabling injuries happen off the job and are not covered by Workers' Compensation coverage, but

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[7] JHA, Inc., *Analysis of 1987 GLTD Table*, The JHA Disability Fact Book, at 30 (2003/2004 ed.).

[8] Health Insurance Association of America, *An Employer's Guide to Disability Income Insurance* at 2, *at www.ahip.org./content/default.aspx?bc=41|329|349* (based upon statistics regarding the Risk of Long Term Disability vs. Death for Males as published in the 2001 JHA Disability Fact Book).

[9] Saylor & Hill Co., *A Valuable Product Many Ignore Talking About*, 46 Benefit Plan Developments Online 5, *at* http://www.saylorhill.com/bpdnews/bpd_v46n5.html.

[10] Princeton Research Survey Associates, *Consumer Federation of America* (Feb. 20, 2001).

are covered by most disability plans.[11] In 2003, the Petitioner alone paid four billion, one hundred million dollars ($4,100,000,000) in disability related benefits.[12] This amount of disability benefit payments is inconsistent with the Tenth Circuit's assumption that Payor Fiduciaries typically reach for unjustifiable interpretations of plan documents that will save them the cost of paying benefits.

Private disability plans provide coverage at a rate which greatly exceeds that of public disability programs. Analysis of the Social Security Disability Insurance (SSDI) program has shown that during the first year of disability, approximately forty-one percent (41%) of those individuals who qualify for disability benefits through their private disability insurance plan do not qualify for SSDI benefits.[13] It often takes several years to receive disability benefits through SSDI. In contrast, Department of Labor Regulations governing ERISA disability plans require that an initial determination on disability claims must be made within forty-five days of the plan's receipt of claim.[14]

II. THE *FOUGHT* DECISION IGNORES A FUNDAMENTAL DISTINCTION BETWEEN THE ROLE OF FIDUCIARIES UNDER THE COMMON LAW OF TRUSTS AND THEIR ROLE UNDER ERISA.

In addition to the lack of any factual documentation for the premise that Payor Fiduciaries generally interpret plan documents in a biased manner, the *Fought* decision presents

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[11] Life Insurance Marketing Association (LIMRA), *Trends in U.S. Household Life Insurance Ownership* (2000).

[12] UnumProvident, Corp., *Our Customer Commitment at Claim Time*, *at* http://www.unumprovident.com/aboutus/ourcompanies/more.aspx#protecting.

[13] America's Health Insurance Plans, *Disability Insurance: A Missing Piece in the Financial Security Puzzle*, at 17-23 (Oct. 2004).

[14] 29 C.F.R. § 2560.503-1 (2004).

many other substantive concerns. For example, the Tenth Circuit disregarded an important distinction from the common law of trusts that Congress intentionally crafted in ERISA. Under the common law, fiduciaries could not occupy ***any*** position that placed them in ***any*** conflict with the trusts or beneficiaries with whom they had a fiduciary relationship. In ERISA, Congress created a limited fiduciary status in which an entity or person who might have interests contrary to those of a benefit plan in one setting, nonetheless could serve as a fiduciary to that same plan for another purpose.[15] For example, ERISA provides that a fiduciary role may be assumed by an individual who is an officer, employee, agent or other representative of the employer sponsoring the plan when that employer is funding plan benefits from its own assets.[16]

The paradigm example involves insurance companies which ERISA allows to serve as claims fiduciaries to a benefit plan despite the fact that, when marketing their insurance products to that same plan, they seek to maximize their economic benefit from that transaction.[17] If Congress believed that these

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[15] 29 U.S.C. §1104 (2005).

[16] 29 U.S.C. §1108(c)(3) (2005).

[17] *See, e.g., Friedrich v. Intel Corp.*, 181 F.3d 1105, 1109-1110 (9th Cir. 1999) (Court cognizant of insurer's dual role); *Taft v. Equitable Life Assur. Soc'y*, 9 F.3d 1469, 1471 (9th Cir. 1993) (Where a plan vests the administrator with discretionary authority to determine eligibility for benefits, the court may only review such determination for an abuse of discretion.); *McMahon v. McDowell*, 794 F.2d 100, 110 (3d Cir. 1986) ("ERISA does not absolutely bar a plan fiduciary from simultaneously serving as a director or officer of the employer or of another party in interest."); *Sutton v. Weirton Steel*, 724 F.2d 406, 411 (4th Cir. 1983) ("Congress . . . has not prohibited an employer who is also a fiduciary from exercising the right accorded other employers to renegotiate or amend . . . unfunded contingent benefits payable before normal retirement age."); *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2d Cir.

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circumstances were unacceptably prejudicial to plans and their members, it easily could have followed the common law of trust model, but it did not. In *Fought*, the Tenth Circuit does not disclose the basis for its authority as an Article III court to reject the policy decision made by Congress that persons could have multiple relationships with ERISA plans, some of which put them in adversarial positions to those plans, but still serve the same plans as fiduciaries for other purposes.

Critically, Congress did not create different classes of fiduciaries to whom various levels of deference would be due by the courts. Congress did not differentiate between fiduciaries with no conflicts of any kind with the plans they served and those fiduciaries with conflicts in the context of a relationship other than as a fiduciary. The Tenth Circuit nowhere identifies in its decision a source of judicial authority to create classifications of fiduciaries, but acts as if such authority existed. In *Firestone*, this Court did not undertake to engraft onto ERISA new classes of fiduciaries whose interpretations of plan documents were subject to different levels of judicial deference. *Firestone*, 489 U.S. at 111-113. The Court focused on the provisions of ERISA which grant to employers and other benefit plan sponsors a right to design the structure of their plans and, in that context, determine the extent of authority and discretion of the plan fiduciaries to interpret plan documents.[18]

Critically, the Court in *Firestone* decided whether a deferential standard of review of fiduciary decisions was

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1982) (Transactions under ERISA expressly permit "investment of up to ten percent of the fund assets in securities issued by the employer of the employees who are participants in the plan. Since such an employer will often be an administrator of his plan, or will function as a trustee or in some other fiduciary capacity, this provision creates a limited exception to the listed proscription against self-dealing. The exception is made in recognition of the symbiotic relationship existing between the employer and the plan covering his employees.").

[18] *Firestone*, 489 U.S. at 113-114.

warranted, or not, on the basis of the fiduciaries' authority specified in the plan documents.[19] The Court did not condition the use of the deferential standard of review on whether the fiduciary had any other relationship to a plan that involved self-interest. In *Fought*, the Tenth Circuit rejected the teachings of *Firestone* by asserting the directly contrary proposition that courts may reject a plan sponsor's decision to grant interpretive discretion to Payor Fiduciaries by denying a deferential standard of review to such fiduciaries' interpretations of plan documents. The *Fought* decision also increases the burden of Payor Fiduciaries to justify their interpretations to a level greater than that required in a de novo review by imposing the presumption that Payor Fiduciaries are biased. 379 F.3d at 1003.

III. THE TENTH CIRCUIT'S DECISION UNDERCUTS THE INTENT OF CONGRESS TO ENABLE ERISA PLANS TO PROVIDE UNIFORM BENEFITS TO THEIR MEMBERS AND TO ADMINISTER AND FUND THEIR BENEFITS IN A PREDICTABLE MANNER

A clear intention of Congress in enacting ERISA was to enable employers to offer benefit plans to employees that would be uniformly interpreted and administered in all jurisdictions in which such employees were located.[20] Uniformity of interpretation and administration are critical to a plan sponsor's ability to project its costs in connection with the offering of health and welfare benefit plans. *Id.* The experience of AHIP's and ACLI's members is that predictability of cost is highly important to employers making decisions about what kind of benefit plan, if any, to offer to their employees. Therefore, consistency of interpretation of plan document provisions is critical to plan sponsors.

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[19] *Id.* at 115 .

[20] 29 U.S.C. §§ 1000(b), 1000b(c) (2005); *see also District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 127 (1992); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987).

Fought frustrates employers' need for uniformity and consistency. Under *Fought*, any time that a fiduciary also is a payor, its interpretations of plan documents not only are subject to judicial review, they are subject to a hostile standard of review predisposed to reject those interpretations on the basis of a presumption of bias. This burdensome standard of review has three adverse effects on employers: (1) inviting more costly litigation over the interpretation of plan documents by claimants who believe that the presumption of bias frees them from the burden of asserting a colorably legitimate claim; (2) increasing the cost of such litigation by, at a minimum, shifting the burden of proof to the Payor Fiduciary; and (3) facilitating the ability of courts to substitute their own interpretations of a plan's documents for those of the plan's designated claims fiduciary without regard to the fiduciary's experience, knowledge of the operation of the plan, understanding of the expectations of the participants, or the quality and competence of its performance as a claims fiduciary.

IV. THE PRESUMPTION OF BIAS IN *FOUGHT* IS IRREBUTTABLE AND ALWAYS LEADS TO A STRINGENT AND HIGHLY BURDENSOME STANDARD OF REVIEW

Fought purports to provide Payor Fiduciaries a right to prove their lack of bias, but that right is illusory. The basis for the presumption of bias is the fiduciary's ***status as a payor***. As long as the fiduciary was a payor at the time of its interpretation of the plan document at issue, it cannot prove it was free of bias because, under *Fought*, Payor Fiduciaries are biased by definition. The consequence of a Payor Fiduciary's inability to prove lack of bias is that their plan document interpretations can never be reviewed either under the deferential standard or the de novo standard, but only under some other, presumably harsher and more burdensome, standard.

This understanding of *Fought* is the ***only*** one that makes sense. *Fought* rejects the arbitrary and capricious standard,

holding that biased fiduciaries are not owed any deference. The de novo standard is applicable to fiduciaries who have not been granted the discretion to interpret plan documents and does not address the issue of fiduciaries who may be subject to a conflict in some other relationship to their plan. The Tenth Circuit has concluded that conflicted fiduciaries are irrebuttably biased in their own favor when acting in their capacity as fiduciaries and thus constitute yet a lower class of fiduciary required to bear a greater burden of proof to justify their interpretations. The precise elements of that additional burden are not delineated in the *Fought* decision. What is clear is that Payor Fiduciaries cannot escape being subjected to that burden.

The Tenth Circuit had no basis for its burdensome discrimination against Payor Fiduciaries. The *Fought* opinion does not point to any objective data proving that Payor Fiduciaries typically make unreasonable plan document interpretations for reasons of economic self-interest. Similarly, there is no citation in *Fought* to objective data showing that the frequency with which Payor Fiduciaries interpret plan documents to deny benefits is greater than that of other fiduciaries.

V. THE TENTH CIRCUIT'S DECISION IN *FOUGHT* WRONGLY ASSUMES THAT IT IS IMPROPER FOR A PLAN FIDUCIARY TO CONSIDER BROAD ECONOMIC AND OTHER FACTORS WHEN INTERPRETING PLAN DOCUMENTS

One of the flaws in the ruling of the Tenth Circuit is its implicit assumption that plan document interpretations that do not focus solely on the circumstances of the plan participant whose claim is under consideration are inconsistent with the proper performance of ERISA fiduciary duties. An ERISA fiduciary's duty does not run only to individual plan participants, but is owed to all participants and their beneficiaries in the aggregate. 29 U.S.C. §§ 1104(a)(1), 1104(a)(1)(A), 1104(a)(1)(D); *Barnhart v. UNUM Life Ins. Co.*, 179 F.3d 583,

584 (8th Cir. 1999)(fiduciary obligations of ERISA plan administrator extend to entire plan, not just individual claimants.); *Turner v. Fallon Cmty. Health Plan, Inc.*, 127 F.3d 196, 201 (1st Cir. 1997). Congress' election to create a duty owed to all plan members in the aggregate, rather than to individual participants, reflects a sensible recognition that individual participants have a self-interest in interpretations of plan documents that maximize their ability to obtain coverage of the benefits *they* need.[21] If fiduciaries owed their duty to each participant separately, a uniform approach to benefit coverage would be nearly impossible to achieve.

Thus, as between two facially reasonable plan document interpretations – one which favors the coverage of a participant's specific circumstances at the risk of jeopardizing a plan's ability to cover all likely and expected covered claim demands with available assets, and the other which results in a denial of the particular claim, thereby preserving the plan's ability to pay anticipated claims for covered benefits submitted by the other plan members in the aggregate – the fiduciary's duty would be to choose the interpretation which protects the members in the aggregate. *Barnhart*, 179 F.3d at 589. The circumstance that the fiduciary making the decision is a Payor Fiduciary does not alter either the character of the duty or of the proper choice.

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[21] Unlike the Tenth Circuit, Congress did not equate self-interest with evil motives or a proclivity for improper conduct. Although plan participants are subject to a self-interested approach to plan benefit coverage, Congress nonetheless empowered them to seek relief from benefit denials they believed were not justified. *See* 29 U.S.C.§ 1132 (a) (2005).

VI. THE STANDARD OF REVIEW IN *FOUGHT* IS INCONSISTENT WITH THIS COURT'S RULINGS IN THE *NORD* AND *DAVILA* CASES [22]

Coverage disputes in the context of disability benefit programs focus on whether the claimant is disabled – i.e. is actually unable to perform some defined level of work. *Just the Facts: A Call for Clarification and Simplification of the Eleventh Circuit's Standard of Review for an ERISA Claims Fiduciary's Factual Determinations*, 5 Mealey's Litigation Report: Disability Insurance 13 (Karen Miehle, ed. July 2004) ("The vast majority of disability claims involve factual disputes, not disputes over plan interpretation."). *Fought* effectively makes a treating physician's finding of disability ***the*** determinative coverage decision by rejecting any contrary coverage determination by a Payor Fiduciary as always impermissibly biased. *Fought*, 379 F.3d at 1006.

In *Aetna Health Inc. v. Davila*, 124 S. Ct. 2488 (2004), this Court emphasized the substantive distinctions between the roles and obligations of treating physicians and those of physicians acting as medical directors of an ERISA plan. *Id.* at 2501. The Court rejected the proposition that judgments about proper medical treatment and care made by treating physicians should be controlling with respect to benefit coverage determinations. *Id.* at 2502. As directly relevant to the present case, and unlike the Tenth Circuit in *Fought*, the Court was not swayed by arguments that plan medical directors' judgments were affected by the economic stakes their employers had as payors of benefits and should, therefore, be rejected. *Id.* Contrary to the clear ruling in *Davila* that plan medical directors' status as Payor Fiduciaries was not a proper basis for invalidating their coverage determinations, the Tenth Circuit has made that very same status the basis for a presumption of invalidity and impropriety with respect to medical directors' coverage determinations. *Fought*, 379 F.3d at 1015.

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[22] *Aetna Health Inc. v. Davila*, 124 S. Ct. 2488 (2004).

Similarly, in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 831, 833 (2003), the Court declined to apply the "treating physician rule" to disability coverage provided by ERISA plans on the grounds that the ERISA requirement for full and fair consideration of the employee's claim did not require that the opinions of the employee's treating physicians be given controlling weight. The Court ruled in *Nord* that the standard was unique to the Social Security Disability Program.[23] In a ruling directly applicable to *Fought*, the Court held that the standard was inconsistent with the discretion and deference to be provided to claim fiduciaries under ERISA. The Tenth Circuit's decision in *Fought* is clearly at odds with the Court's prior relevant rulings.

VII. ERISA DRAWS UPON CONTRACT LAW AND CONTRACT CONSTRUCTION PRINCIPLES FOR THE INTERPRETATION OF PLAN DOCUMENTS, AND THE DECISION BELOW IMPROPERLY IGNORES AND SKEWS THAT LAW AND THOSE PRINCIPLES.

ERISA plan documents are contractual in nature and ERISA jurisprudence draws from contract law. ERISA jurisprudence is a blend of the law of trusts and the law of contracts. *See Firestone*, 489 U.S. at 112-113. The Tenth Circuit's decision in *Fought*, however, filters out the contract law elements, and substitutes a reversion to the strict common law of trusts fiduciary principles that Congress rejected in drafting ERISA. In *Fought*, the Tenth Circuit has equated contractual self-interest to a pervasive corrupt motivation that disables a contracting party from being objective and complying with its legal obligations as an ERISA Fiduciary. This equation has no support in ERISA jurisprudence or contract law.

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[23] 20 C.F.R. § 404.1527(d)(2) (2004) (noting that under the **treating physician rule,** opinions of physicians who have treated the claimant receive controlling weight if they are well-supported by medically acceptable clinical and laboratory diagnostic techniques, and are not inconsistent with the other substantial evidence in the case record).

ERISA, as previously demonstrated, was designed by Congress to be a far less rigid and inflexible instrument of fiduciary governance than the common law of trusts with respect to allowing parties to be both fiduciaries to a plan and to have other relationships with that same plan which give rise to conflicts between them. Thus, ERISA is consistent with principles of contract interpretation which do not penalize parties to contracts for having economic self-interests in how those contracts are interpreted.

This is important because it is indisputable that plan participants have a clear economic self-interest in how their plan's documents are interpreted. The participant's interests and those of his advocates - e.g., physicians -define and drive their interpretations of plan documents to obtain the broadest level of benefit coverage possible. *See Nord*, 538 U.S. at 832. Yet, it would be shocking if a court were to rule that participants' self-interest taints them so that they must prove a lack of bias in addition to proving that an interpretation they have proffered is objectively reasonable. There is no precedent for a rule under contract law that a party with an economic interest in a particular contract interpretation should be penalized for having that interest.

Courts ordinarily will not rewrite contracts when there is a dispute as to the meaning of their terms. CORBIN ON CONTRACTS § 24.19. The Tenth Circuit's decision, however, seems to require courts to rewrite plan documents whether they consist of insurance policies or self-funded arrangements. The *Fought* decision mandates that any plan document interpretation proffered by a Payor Fiduciary is suspect and unacceptable unless the irrebuttable presumption of bias is overcome by meeting some undefined higher burden of proof as to the propriety of the interpretation. This holding effectively excises from plan documents provisions granting a Payor Fiduciary the discretionary authority to interpret those documents by prohibiting the application of the deferential standard of review

attendant to that authority. The *Fought* decision is a clear example of judicial rewriting of insurance and other plan benefit documents to accommodate a particular court's policy view of the appropriate scope of benefit coverages. E. Haavi Morreim, *Benefits Decisions In ERISA Plans: Diminishing Deference To Fiduciaries and An Emerging Problem For Provider-Sponsored Organizations*, 65 Tenn. L. Rev. 511, 516 (1998)("In some of these cases, judges' contract interpretations strain so hard to favor the pleading plaintiff that some commentators have criticized their decisions as 'judge-made insurance.'"). By nullifying clauses that empower Payor Fiduciaries to have their interpretations reviewed under an arbitrary and capricous standard, the Tenth Circuit has freed the courts to substitue their own interpretations.

VIII. THE MARKET WILL PUNISH INSURERS WHO UNJUSTIFIABLY DENY CLAIMS

The assumption that a fiduciary who is also an insurer is likely to err on the side of denying benefits ignores the realities of both the employer-employee relationship and the insurance market. These realities have been recognized by several courts:

> It is a poor business decision to resist paying meritorious claims for benefits. Companies . . . that sponsor ERISA plans are customers who choose which group insurance policies they will use to fund their plans . . . these employers want to see their employees' claims granted because they want their employees satisfied with their fringe benefits. These corporate employers have the sophistication and bargaining power necessary to take their business elsewhere if an insurer . . . consistently denies valid claims. In the long run, this type of practice would harm an insurer by inducing current customers to

> leave and by damaging its chances of acquiring new customers.[24]

In making benefit coverage decisions, business and competitive forces compel insurers to act reasonably. "Affirming reasonable claim determinations in an expeditious fashion achieves ERISA's competing goals of paying benefits and making the cost of coverage more affordable, for the benefit of all. . . .We would not be successful if our policyholders concluded we were treating their employees unfairly."[25] The quality and quantity of services offered by insurers affects how well they fare against competitors. An important goal for employers in paying for benefits is to maintain a satisfied and motivated workforce. Group insurance purchasers typically are sophisticated and base their purchasing decision more on price and service considerations than any other factors. *Marketing Life and Health Insurance* 190 (Nancy E. Strickler ed., 1981). If an insurer is perceived as engaging in unreasonable denials of coverage, its clients will not continue to do business with that insurer.

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[24] *Mers v. Marriott Int'l. Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998); *see also Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999) (an insurance carrier "can hardly sell policies if it is too severe in administering them"); *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1998) ("an employer would not want to keep an overly tight-fisted insurer" and therefore "the conflict is not as serious as might appear at first blush").

[25] Testimony of Lawrence Frank, Standard Insurance Company, Before the Health and Managed Care (B) Committee and Consumer Protections (EX) Working Group of the National Association of Insurance Commissioners (June 14, 2004).

IX. THE EXTREME STANDARD OF REVIEW IMPOSED BY THE TENTH CIRCUIT IS A COSTLY BURDEN THAT IS UNNECESSARY GIVEN THE SAFEGUARDS AGAINST FIDUCIARY ABUSE PROVIDED BY ERISA.

The current standards of judicial review have not been demonstrated to allow fiduciaries to act in disregard of their extensive fiduciary obligations, or in violation of the fiduciary self-dealing prohibitions of ERISA Section 406(b).[26] Fiduciaries are subject to extensive duties and prohibitions against fiduciary self-dealing as set out in ERISA. *See, e.g.*, 29 U.S.C. §§ 1104 and 1106(b) (2005). They may be held personally liable not only for their own conduct that violates their obligations under the statute, but also for failing to prevent or to take action against other fiduciaries who are committing or have committed fiduciary breaches.[27] Fiduciaries who self-deal in violation of Section 406(b) are subject to substantial fines and penalties by the Secretary of Labor. *Id.* § 1132.

From a commercial perspective, insurers and other Payor Fiduciaries who intentionally violate their duties under ERISA run a risk that they may be barred, or enjoined, from serving as ERISA fiduciaries to any ERISA plans, or even from engaging in transactions with ERISA plans. Any such consequence would be financially devastating. The Tenth Circuit's presumption of bias adds little, if any, additional deterrent effect. This is so because ***the Fought standard of review is based on fiduciary status, not fiduciary conduct.*** A Payor Fiduciary whose conduct has conformed in all respects to ERISA's fiduciary standards nonetheless remains subject to that punitive standard of review. A Payor Fiduciary who has violated ERISA's fiduciary standards is not subject to any adverse consequences under *Fought*.

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[26] 29 U.S.C. § 1106(b) (2005).

[27] *See, e.g.*, 29 U.S.C. §§ 1109 and 1132(a)(3) (2005).

X. CONCLUSION

For all of the foregoing reasons, the petition should be granted.

Respectfully submitted,

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